Starter Kit for Behavior Change for Vitamin A Distribution

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Key Behavioral and Communications Issues for Vitamin A Distribution

MOST
The USAID Micronutrient Program

This publication was made possible through support provided by the Center for Population, Health and Nutrition of the Bureau for Global Programs, Field Support and Research of the U.S. Agency for International Development (USAID).

MOST is managed by the International Science and Technology Institute, Inc. (ISTI) under the terms of Cooperative Agreement No. HRN-A-00-98-0047-00. Partners are the Academy for Educational Development (AED), Helen Keller International (HKI), the International Food Policy Research Institute (IFPRI), and Johns Hopkins University (JHU). Resource institutions are CARE, the International Executive Service Corps (IESC), Population Services International (PSI), Program for Appropriate Technology in Health (PATH), and Save the Children.

June 2000

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HEALTH WORKER / SYSTEM PROVIDER

SKILLS AND PRACTICE

Step 1. Agree upon and clearly state expected behaviors.

It is very helpful to state clearly the practices you wish key players to adopt. This is best done through agreement with those most involved, including nutrition units, ministries, and the health workers themselves. They must find the expected behaviors feasible, reasonable, and acceptable. It is important not to have unrealistic expectations. For example, useful performance objectives for providers during a NIDs or mass vaccination program are to
—Administer the supplements correctly
—Tell the caretakers that the child is receiving vitamin A
—Remind the caretaker when to come back
—Say something positive to the caretaker about participation:
"Thanks for coming" or "You're a good mother to be getting this vitamin A for your child," etc.

Step 2. Identify the existing behaviors.

The first step in improving, assuring, or supporting these practices is to have a clear idea of what is actually occurring in the field. Most countries can take advantage of the vitamin A capsule distribution that accompanies the NIDs each year to collect these data. We have worked with several countries to develop instruments—*simple checklists for observation of the contact* and *exit interviews with the caretakers*—that can be used to monitor the contact between the capsule providers and caretakers to identify performance problems and gaps and to learn their perspective on the experience. One can also learn what caretakers know and think about vitamin A and vitamin A capsule distribution and exactly how long the average contact lasts. These findings can easily be used to design training and worker aids and to give ideas for communications.

See *Measuring the Quality of the Contact between Client and Provider during Vitamin A Distirubution: An Easy-to-Use Monitoring Tool* [click here] which contains examples of these forms and instructions for training in their use. They can be used to collect either quantitative or qualitative data. See also *Analysis of Observation Reports from a Vitamin A Supplementation Campaign in Zambia* [click here] and *Report of Monitoring Effort in Ghana* [click here].

Step 3. Identify gaps & barriers to adopting expected behaviors.

What gaps and barriers should we look for in establishing supplementation programs?

Skills

Experience has taught us that workers need to be and to feel competent in administering vitamin A capsules correctly—proper dosage, estimating age, cutting capsules, vomiting children, tallying, etc. These skills are more complex than expected and need careful training. Demonstration with practice works best, with the opportunity to problem-solve; for example, ask workers to demonstrate how to use a 200K for a child under one (or under six months if these are included in your protocols).

Communication

Providers also need to know exactly what communications with caretakers are expected; e.g. at a minimum, they should tell them that the child is receiving vitamin A, when to come back, and something positive so that the encounter is a positive one for the caretakers ("thank you," "you're a good mother," "this helps your child"). You have learned in your observation how much time is actually available during the provider-caretaker contact. If there is time during the NIDs/measles campaign, or later during a non-NIDs vitamin A focus campaign, a short message on the value of vitamin A capsules can be given. If there is not enough time during a vitamin A capsule-only campaign for your messages, you might consider allowing more days for the campaign. It only frustrates providers if you ask them to provide more messages than they, in fact, have time for. The amount of information has to fit into the time available, so shrink the messages or expand the time. We find that offering providers a choice of benefit messages relieves some of the boredom of repeating the same lines; for example, they can choose from this protects your child, saves lives, keeps your child healthy, is like an immunization, makes healthy children, makes children strong, helps them grow well, be energetic, survive serious illness, or other messages the audience sees as persuasive.

Observations to date have shown that some workers in some countries treat clients poorly, although this seems to be a case of neglect rather than harshness. They fail to give them the key or any messages, or they make them wait, not respecting their time. Interestingly, it was noted in the monitoring observation in Zambia that workers who were respectful of client time had better attendance and coverage than those who did not.

Observations of vitamin A capsule distribution during a NIDs

"What I observed was that there was no (repeat, *no*) communication related to vitamin A or immunization between the volunteers and the caretakers who brought the children. Volunteers did not ask questions to screen for age, they did not tell caretakers what was being given to the children, they certainly did not say anything about the benefits of what was being given, and they told them nothing about when they might want to get more of the same medication. They did not even tell caretakers when (i.e., in five weeks) to come back for the next NID. The list of tasks not carried out goes on and on. For example, I observed several volunteers who did not directly tally the children who received vitamin A. When asked about the tallying, they said that they would wait until a group of children were finished then tally the doses they remembered. Another volunteer said that he just relied upon the tallying of polio doses. Shortages of vitamin A were reported at a sizeable minority of sites. Blue capsules were in especially short supply. This seemed largely related to difficulties estimating how much vitamin A to supply to each site. In the site I visited, it was also related to dosing of over age children."

Attitudes and motivation

Workers, and the health care system in general, often do not understand or value the importance of vitamin A and vitamin A capsules for prevention and tend to be overall more comfortable with treatment than prevention. Possible issues include the following: the system and its leaders do not place a priority on the activity, it is not in annual plans or budgets, and there is very little support or recognition of the activity outside the NIDs. Vitamin A capsule distribution coverage is often not part of the regular MIS, which further suggests to providers that it is not important—that is, it is not something that is scored for or against them. Routine coverage has often been a low priority, and, whether or not they get good coverage, nothing happens in the way of feedback. No one notices whether or not they do a good job.

Step 4. Take actions designed to overcome identified barriers.

Behavior change theory tells us that the three primary determinants for adopting a new behavior are 1) our confidence that we can do it well, 2) the belief that it will "pay-off" or have a positive outcome for us, and 3) that those important to us approve.

> It is important to make the task of the health workers more user friendly, to increase their self-confidence in participation, to convince them of the cost-benefit of vitamin A capsules, and to provide positive outcomes, through feedback and recognition from the health system and the community, for their efforts.

Training should therefore also focus on motivating these providers, to increase knowledge of the benefits and "pay-off" of vitamin A capsules for the providers and their systems. We have done a series of overheads stressing the mortality effect of vitamin A deficiency in Africa, the gains associated with good coverage, benefits from vitamin A capsule distribution for health services, and a simple formula that allows districts to calculate the expected mortality impact of coverage. See overheads [click here] that have been developed for this purpose in an African country.

The orientation workshops for providers should directly address the issue of motivation and understanding of the benefits of vitamin A capsules. Benefits for the community and for health workers should be discussed and the behavioral expectations clearly stated, discussed, and negotiated. For example, messages should be designed to fit into the contact time available, and changes should be made if providers feel they will be overwhelmed by the new demands. Group problem-solving sessions can help managers think through how they could best anticipate and meet common problems, can help them feel more ownership of the process, and can provide extremely good ideas and analysis. The observation and exit interview findings again can be used here to help people look at issues of quality and client-friendly services. See *Workshop Orientation Session* [click here] for an excellent report from an orientation session conducted in Zambia that is a model for this kind of workshop.

Feedback from the observations should be presented during the orientation sessions to help managers appreciate the problems the health worker in the field encounters, so they can prepare more realistically. We have found that this kind of feedback can be very powerful in helping managers to focus on the reality of the peripheral worker.

A short worker aid that will clearly show dosages, and how to give the capsules, including the correct way to cut, may need to be provided with the capsules.
A mechanism should be put in place to assure that the central level provides recognition for the kind of good work and organization that you will see if you have prepared carefully. A system of incentives, as special certificates for highest coverage centers, choosing high achievers to present their experience in the orientation sessions for the next year, etc., should be put into place. The best way to stop a behavior is to punish it, or to ignore it. Currently, good vitamin A capsule coverage is still not being rewarded or recognized.

> The mass media—journalism, radio, TV—should carry tributes to the hardworking health worker who protects the children of Zambia by providing vitamin A capsules for its children. Messages can call families to receive free vitamin A from their friendly and caring provider.

Local staff should be involved in the observation and exit interviews. This will enable them to understand and correct specific problems in their areas, and show recognition to the workers. This should be a highly supportive rather than critical effort. Observers from the central level (UNICEF, MOH, etc.) should also take part to provide visible support and to themselves understand the problems.

CARETAKER PRACTICE

(DEMAND GENERATION)

The steps are the same for caretaker behavior change, but in the case of supplementation, much simpler than for providers.

Step 1. Choose and state clearly the expected behaviors.

The behaviors expected of caretakers are simpler than those expected of providers and therefore easier to promote.

"Bring your children aged x to the distribution points for the protection of vitamin A twice a year in (month of the year or of child's age, depending on your policy)." For twice-yearly campaigns, you need only tell them to come when they hear the announcements, which should occur in predictable months; e.g., each August and February, which can be identified as 'the vitamin A months." The goal is to make the twice-yearly distributions the norm so that providers and communities take them for granted. If you plan to deliver the capsules through routine services, you will need to decide what you expect mothers of older children to do—come twice a year in special months or at their own child's six-month intervals. The latter is clearly a more difficult practice. Usually, coverage is lower with routine services than with campaigns, especially for children over one year who do not often come to clinics for preventive care.

Step 2. Identify current practices and beliefs.

Findings from the exit interviews described earlier can give you quick ideas about what caretakers know and do not know, what values they see in vitamin A, and where they receive information about vitamin A. These can help to direct the messages for the next distribution.

Step 3. Address identified barriers.

In terms of barriers to be overcome, there are not many. The vitamin A capsules are free, have almost no side effects, protect their child, save lives, makes their children strong and beautiful, etc. A difficulty may be distance if sites are not well sited. Stress that vitamin A protection is aimed at older children, between two and five, as well as the younger children who are targeted for immunizations. Often parents are pleased that their older children are now offered protection and preventive services.

To encourage integration of services and link to already valued immunization, the program could stress that "full immunizations and vitamin A capsules twice a year offer complete protection to your children under x." A popular idea is to take advantage of the vitamin A contact to integrate other child survival services, such as deworming and checking immunization cards. The vitamin A contact offers assess to children older (one to five) than are usually seen at health centers.

On the other hand, there is no immediate, visible benefit in receiving vitamin A; families often do not notice any real changes or notice them over time. It is important then to articulate these benefits in your materials; e.g., “mothers in your community (mothers like you) say that their children are more energetic, healthier, have brighter eyes, after receiving vitamin A.”

Talking points (also called “creative briefs”) should be developed to give all members of the team a clear idea of the behaviors to be promoted, barriers to be overcome, messages or actions to overcome these barriers, a “key promise” that states clearly and persuasively the main benefits from the audience’s perspective of vitamin A capsules or vitamin A, the tone to use in discussing the issue, etc. This helps to focus messages and communication on key resistance points, promotes consistent and correct messages, and helps take advantage of every opportunity for radio and TV interviews, talks with groups, etc. *Creative Briefs* [click here] provides examples of such talking points and the forms that can be used to develop them.

BUILDING SYSTEMS

In order to create a permanent system that supports and reinforces behaviors it is useful to set up *monitoring and feedback loops* that provide feedback at the district or smallest administrative level to the providers. This can first be done by or with technical assistance at the central level but should include training for local staff to carry out this monitoring for themselves. This has proven extremely valuable in several countries, helping to keep providers motivated and able to fix problems immediately.

A good way to do this is a *simple household coverage survey* that validates your coverage. Other questions on caretaker knowledge of the five "W's" (what are vitamin A capsules, where and when do you get them, who are they for, and why do you want them), their sources of information about vitamin A, whose opinion matters about this, etc., can be added to help you with your communication planning. *Example of a Household Survey* [click here] provides a good example of a simple and inexpensive household survey. These are relatively quick to do on a national level, requiring approximately $3–5 thousand a round. It is much cheaper when local staff begin to do their own.

Measuring the Quality of the Contact between Client and Provider during Vitamin A Distribution

An Easy-to-Use Monitoring Tool

Field-tested
in Zambia by the National Food and Nutrition Commission
and in Ghana by the Nutrition Unit of the Ministry of Health

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Background and Introduction

A key to improving coverage and programming for vitamin A capsules (VAC) is assuring that the contact between caretakers and providers during vitamin A distribution is pleasant, the dosage is correctly given, and the needed messages are given and understood. In Ghana and Zambia, MOST field-tested simple, short checklists for provider behavior that can be used by local programmers, and an exit interview that provides an indication of how much and what the caretaker understood from the encounter.

Once collected, the data can quickly be fed back into the health care or volunteer system to improve training, support, communication, protocols, etc., as needed, and to provide baselines for future activities. Experience shows that the value and credibility of the findings are enhanced when the data are collected by those most involved in the effort, including donors, central-level planners and technical specialists, and the local staff responsible for the activities. Using program staff to collect data encourages their "self-discovery" of good examples as well as problems and makes it more likely that they will accept changes based on those data. In addition, these studies are relatively inexpensive, costing around $3,000 for a national survey of five districts in Ghana using two-person teams for each district.

The two countries used the forms differently. Zambia, partially due to a travel ban on interviewers, reported descriptive and qualitative findings; while Ghana reported using quantitative analysis. Both countries made discoveries that have already changed the way their programs are organized.

In Zambia, despite assurance at the central level that the providers, who had taken part in several VAC distributions, knew how to administer the capsules, it was obvious that few understood the dosage and even fewer how to cut the capsules when half doses were needed. Health workers did not have cutting instruments, as the central level had assumed, and to their credit, used their teeth and thorns and anything else they could find to open the capsules or asked mothers to use their teeth to open capsules for their children. Despite the lack of skills, training, and supplies, the health workers were motivated and determined, and achieved an unexpected 71 percent coverage in a non-NIDs distribution. Observers also noted that health workers who made it clear that they respected the time of the clients had higher coverage than those who did not.

Based on these findings, preparation for the next distribution will focus on new skills training and job aids and fostering more positive attitudes toward the clients.

The monitoring in Ghana took place during the NIDs on January 15. In one striking finding, observer/interviewers in one district noted that no mothers knew that they had received vitamin A, some thinking that their child had received candy or a toffee, and none knew when or if they were to return. A study can also look at the length of the contact between provider and caretaker, so that realistic messages can be crafted. If the contact during NIDs is, for example, 30 seconds, then we will need to be sure that any messages can be comfortably given during this period. Longer and more complete messages can be planned for use during the vitamin A-only distributions.

These forms should best be used in conjunction with the WHO guidelines, "Distribution of vitamin A during national immunization days" (Department of Vaccines and Other Biologicals and Department of Nutrition for Health Development, WHO, Geneva), to assure a comprehensive look at the entire supply, logistics, planning, and promotion effort.

Training for Observation and Exit Interviews

Observation

The key to successful observation is that all observers agree on criteria for each practice to be observed. The criteria should be discussed in detail in advance with all observers and research leaders. Role-plays in which good and incorrect practices are demonstrated while observers score them should be used to be sure that all observers are scoring the same practice the same way. If there are disagreements, these should be worked out during the training. This is particularly important with practices such as smiling, giving doses correctly, being polite or pleasant, etc. It is easier to observe if a worker smiled than to observe that he is being pleasant, but some teams have been able to agree on criteria and use more subjective measures. If the criteria for any practice cannot be agreed upon so that all observers are scoring them consistency in the same way, they should not be used.

Often the events will not occur in the order given on the form. The observer should be alert to record them as they occur. During the role-plays the trainers should change the order of giving information so that observers can practice entering data out of sequence.

Time Management Studies

For all contacts, note the time the contact begins and ends. This means that each observer will need a watch with a second hand. Please try to be as exact as possible.

Use of Observation and Exit Interview Forms

1. Observe at least five contacts between caretakers and providers at each site. These should be evenly spaced over the time that you are visiting a site so that changes due to numbers being seen, exhaustion, etc. will be recorded. Try to be as inconspicuous as possible in observations. We do not want to make providers self conscious or interfere with their concentration. Explain that we are looking for ways to improve the system. Do not tell providers that you are observing communication practices as well as administration. Assure all that no names will be used. Note that we are using “she” and “her” to refer to caretakers as they are primarily female.

2. Enter the name of the site and district (or other needed identifying information.) Enter a number for the provider you are observing, and number each caretaker contact sequentially. In this way we can match the knowledge of the caretakers with specific practices of the provider.

3. Observation Form for VAC During NIDs

    a. Record yes if the provider asks for the child’s age, *and* asks further questions if the mother or other caretaker cannot answer easily.
    b. Note if the dose is correct for the child’s age.
    c. Since Ghana allows each provider to develop their own system for cutting capsules this practice is not standardized and therefore can probably not be observed successfully. *If* agreement can be reached on the correct practice then it should be observed and recorded.
    d. The provider should be sure the caretaker knows that her child has received vitamin A.

e. The observers should agree on the criteria for this practice. If there are specific vitamin A messages that should be delivered the delivery of each of these messages should be observed and recorded. If no specific messages have been given to providers then they should say something positive and welcoming, as You are a good mother, this is good for your child, vitamin A will help your child, thanks for coming, welcome, etc.
f. The provider should tell her when to return—in six months, every six months or in August.
g. We are not asking if the provider notes the VAC in a card or tally sheet as we understand this is the responsibility of another person. If this is the responsibility of the provider then this practice should be observed and recorded.
h. Often providers are asked to keep Vitamin A capsules out of the sun. *If* this is policy in Ghana, add a question so you can observe and record this practice.

4. After observing the contact the observer should question the caretaker. Explain that you are trying to find ways to make the distribution more helpful to people like her, and that the caretaker can help you to find out what she thinks about the encounter. The key to success in exit interviews is not to alarm or intimidate the mother.

5. Exit Interview for VAC

   a. Ask open questions rather than questions that can be answered with yes and no as this provides a more reliable test of her knowledge. For example, ask, what did your child just receive from this worker?, rather than did your child receive vitamin A?
   b. Ask her if she knows when she should return. Correct answers are in six months, every six months, or in August.
   c. Ask her what age children are supposed to come for this dose? The correct answer is all children between the ages of six months and five years.
   d. What are some of the benefits of the vitamin A capsule? There are many correct answers. Interviewers should agree on acceptable ones, and should list those given for future use in communication campaigns.
   e. Ask her if she intends to return for the next dose.
   f. Ask if she thought the provider was polite, or ask if she found the distribution experience pleasant. It is unlikely that you will get much variation in the former, so that the latter question may be more useful. Another approach, although it cannot be analyzed quantitatively is to ask “What did you like best about the distribution, and what did you like least about the distribution.
   g. Ask if she knew that vitamin A was going to be given today?
   h. If yes, ask her where she heard this information? Check the sources she mentions for information about the VAC. These will be very useful for the communication strategy.
   i. Note the time that the contact begins and ends.

Site_____
Provider no._____
Mother no._____
Time started_____

Observation Form for VAC during NIDs

Action	Yes	No
a. Determines child's age		
b. Gives correct dose		
c. Cuts correctly		
d. Tells mother child is receiving VitA		
e. Welcomes mother *or* Says something encouraging or positive to mother about receiving VAC		
f. Tells her when to return		

Time ended_____

Site_____
Provider No. _____
Mother No._____

Exit Interviews for VAC

Action	**YES**	**NO**
a. Can state that her child received VITA		
b. Can state correctly when to return		
c. Can state correctly who is eligible (6 months to five years)		
d. Can state benefit/s of VITA List: (protects child, prevents blindness, makes child grow stronger, etc.)		
e. Says HW was polite/welcomed her		
f. Says she will or will not return for the next dose		
g. Say she did or did not know that VAC would be distributed today.		
h. If yes, says where she heard about VAC distribution Check all mentioned:		
Health worker		
Religious leader		
Local leader		
Leaflet/poster/sign/banner		
Neighbor/friend/relative		
Radio		
Other (list)		

Report of Monitoring Effort in Ghana

REPORT ON MONITORING VITAMIN A CAPSULE DISTRIBUTION WITH NID

JANUARY, 2000

COMPILED AND EDITED BY

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ACKNOWLEDGEMENTS

The Nutrition Unit and Micronutrient team are most grateful to MOST/USAID for the technical assistance and financial support for the Monitoring exercise. We are also grateful to Dr. Bob Pond for the technical input.

We would like to thank the team members for collecting the data and the Regional Health Directorates for their support during the data collection exercise.

Finally we wish to express our gratitude to Mrs. Evelyn Lamptey and Wilhelmina Okwabi for assisting with the data analysis.

Micronutrient Team.

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EXECUTIVE SUMMARY

Introduction:

This report summaries, findings of the monitoring exercise carried out during the distribution of Vitamin A capsules (VAC) with the administration of Oral Polio Vaccine (OPV) on the National Immunization Day (NID) in January 2000.

Objectives:

The objectives of monitoring VAC distribution that has been integrated into the NIDs for three years now, were:

- to provide the needed data on progress of implementation
- to assess the effectiveness of the training and IEC activities and
- to monitor logistics supplies

Information collected will be used to improve coverage and ensure safety of VAC distribution.

Methods:

A total of 24 immunization sites were selected from 5 randomly selected regions.
At each site team members spent about an hour observing immunization and administration of capsules to cover caregivers and recording observations on a structured form.

Exit interviews were then done on 10 caregivers at each site using a questionnaire.

The exercise was carried out in four of the selected sites in one district during the sub-NIDs.

Training was carried out for 2-member monitoring teams for each of the selected regions.

Results.

The results from the monitoring exercise summed up in tables A,B, C and D showed that there was generally little or no communication between the service provider and the caregiver apart from asking questions to determine age of the child before dosing. There was little communication to inform caregiver what child was receiving or a reminder to return for the next dose of VAC or OPV. Only one in twenty mothers received any form of recommendation for bringing their child.

Capsule handling and administration was however better practiced with almost all providers (94.5%) giving proper age-specific dose and most providers emptying capsule completely. Only two-thirds of providers however, cut capsule correctly.

Communication with caregivers on the OPV immunization showed a similar but slightly better trend.

From exit interviews, about a third of mothers were aware their wards had received VAC with twice that number being aware their ward had received polio vaccine. Knowledge about the NID activities

among mothers/caregivers was generally low and very few knew about the second round of distribution of VAC to take place in July 2000.

Conclusion:

The results of the monitoring exercise raise pertinent questions regarding effectiveness of training, IEC and social mobilization activities. There is the need to review training IEC and social mobilization techniques and approaches as well as intensify supervision during training.

SUMMARY OF FINDINGS

Table A: Summary of activities observed for.

NO	ITEM	RESPONSE %		
		YES	NO	N/A
1.	Determination of age of target child for VAC	87.9	12.1	-
2.	Administration of proper dose of capsule	94.5	5.5	-
3.	Post staff cuts capsule correctly	65.4	25.8	8.8
4.	Post staff/empties capsule completely	88.7	4.6	6.7
5.	Post staff informed caregiver child is receiving Vitamin A	17.9	82.1	
6.	Post staff encourages or commends caregiver	4.6	95.4	
7.	Caregiver informed to return for VAC	0.9	99.1	
8.	Post staff gave correct OPV dose	95.4	4.6	
9.	Mother/caregivers informed to return for Polio 2	30.4	69.6	
10.	Mother/caregiver informed to continue routine immunization	8.4	80.3	11.3

* N/A stands for Not Applicable

Table B: Summary of questions and responses for exit interviews

NO	QUESTION/ITEM	RESPONSE %		
		YES	NO	N/A
1.	Proportion of mothers/caregivers aware child received VAC	36.7	63.3	
2.	Proportion of mothers caregivers aware child received OPV	62.9	37.1	
3.	Proportion of caregivers aware when to return for round 2 of Polio	26.7	73.3	
4.	Mothers who could say when to come for round 2 of VAC	3.3	96.7	
5.	Caregivers could say they need to continue with routine immunization	45.8	54.2	
6.	Caregivers aware of eligible target age group for VAC	21.7	78.3	
7.	Caregivers with knowledge on benefits of VAC supplementation	49.6	50.4	
8.A	Caregiver willing to return for next VAC dose	72.8	9.6	

Table C: REASONS FOR WILLINGNESS/NON-WILLINGNESS TO RETURN FOR VAC ROUND 2

REASON	CAREGIVERS % RESPONDING
No Reason/No response	5.6
For health of child/Good for child	27
To prevent child against illness	30
To ensure health growth of child	10.2
Was asked to come	4.1
Was not asked to com	7.6
Others	16.3

Table D: Sources of information on the NID activity

SOURCE	CAREGIVERS % RESPONDING
Gong gong beater/town crier	32.9
Mobile van/Public Address System	21.3
FM/Radio	17.1
Health worker/CWC/Clinic	23.7
Friend/Husband/Other relation	19.2
Volunteer	7.6
Others	17.9

Introduction:

Vitamin A Capsule distribution has been integrated into the National Immunization Days (NIDs) for over three years. Although the impact can be measured periodically there is the need for careful and regular monitoring of the various stages of the implementation process.

This will among others, provide the needed data on progress of implementation, assess effectiveness of training and Information, Education and Communication (IEC) activities and monitor logistics supplies. The data will also input into the review of activities to ensure the effectiveness of the programme implementation, particularly in delivering required quantities of supplement and increase coverage.

Objectives:

The objective of exercise was to collect data that will be used to assess effectiveness of training and IEC awareness creation, ensure safety capsule administration and improve coverage.

Methods:

Six regional teams were formed, each team assigned to a region with an additional team to visit a hard to reach area during the Sub-National Immunization Days (SNIDS). All team members were trained and the monitoring and training activities were coordinated and supervised by two national teams.

Sample Size Selection and Sampling:

Five regions were randomly selected and in each region a district was randomly selected. Within the selected district, 2 sub-district were chosen and 2 communities or 2-immunization points chosen. At each site, team members spent at least an hour observing immunization and administration of capsules by service providers and observations made recorded on a form.

Exit interviews of 10 caregivers were done using a set of questions immediately after leaving immunization points. Appendices A & B show samples questionnaires used.

Training:

A one-day training session was held for team members from the six selected regions.
The purpose of the training session was to discuss the objectives of the monitoring exercise, introduce members to observation and interview guides to ensure uniformity in interviewing and observation.
The training covered the purpose, focus and objectives of the monitoring exercise, selection of samples and in-depth discussion of exit interview and observation guidelines. There was also a trial of interview techniques and pilot of procedures as well as a demonstration of how to cut Vitamin A capsule nipples correctly and empty capsule content completely. There was also a discussion and demonstration of how to administer half the content of 200,000 IU capsule to infants (6-11months) when the need arises.

Information Collected:

Data collected covered administration of correct dose of vitamin A and Oral Polio Vaccine (OPV) to target child through age determination, proper cutting of capsule nipple and emptying of capsule by providers. Information on attitude of service providers in communicating benefits of Vitamin A, giving reminders and encouragement to caregivers was observed and recorded.

In addition information on promotional activities to create awareness and demand and sources of the information was also complied.

Data Processing and Analysis

All completed forms were reviewed and checked for consistency and completeness. The data was tallied on dummy tables manually, summary sheets prepared and percentages calculated.

RESULTS:

1.0. OBSERVATION OF VITAMIN A CAPSULE (VAC) ADMINISTRATION

1.1. Determination of Child's age (Table 1.1):

In most of the observations (87.9%) determined the age of target child before administration of capsule.

Of the six regions, Volta region performed poorest with 42.5% of observations in which child's age was not determined prior to administration. Western and Brong Ahafo regions followed with 17.5% and 10% of observations in which child's age was not determined.

1.2. Giving correct dose of VAC (Table 1.2)

On the whole about 95% of providers (volunteer/health worker) gave the correct dose of Vitamin A. Regions that performed poorest were Greater Accra and Volta regions with 22.5% and 10.5% of providers not giving the right dose respectively.

Cutting and emptying capsule correctly (Table 1.3, 1.4):

About two-thirds – 65.4% of providers did cut capsule correctly on the whole.

Eastern region performed poorest with three quarters of the capsule (75%) being pierced with a needle. In Northern region, almost half of the administered capsule (47.5%) was pierced with a pin. Some children (close to 10%) were however allowed to swallow the capsule whole –

On the whole about 95% of administration of capsule providers emptied the capsule. From observation it appeared capsule was really emptied by most people for most children.

1.3. Information to caregivers about VAC(Table !.%, 1.6):
A vast majority of mothers (82%) were not told what the child was receiving.

However in Eastern region, 42.5% and in Brong Ahafo 32.5% of providers did tell mother that child was receiving vitamin A.
On the whole, 95% of providers did not say any encouraging word to commend caregivers for bringing to receive the immunization and vitamin A capsule.

Only 2 mothers encountered in Greater Accra region were told when to return for VAC. The others were not given any information or reminder.

1.4 Giving of correct OPV dose (Table 1.8):

Most children observed (95.4%) were given the correct dose – 2 drops of the polio vaccine.

1.5 Information on when to return for polio 2 round 2 of VAC and Routine immunization (Table 1,7,1.9, 1.10):

Just about a third of mothers (30.4%) were told when to return for polio 2, on the whole. In Western and Northern regions no mother/caregiver was given this information.

In 5 out of the 6 regions monitored, no mother was told when to return for vitamin A. In one region, Greater Accra, it was observed that only 2 mothers out of the 40 observed were given this information.

Only 8.4% of caregivers were informed or encouraged to continue with routine immunization. The majority received no such information.

OBSERVATION:

TABLE 1.1: Determination of age of target child

REGIONS	YES		NO		TOTAL	
	No.	%	No.	%	No.	%
NR	40	100	-	-	40	100
BA	36	90	4	10	40	100
WR	33	82.5	7	17.5	40	100
GAR	40	100	-		40	100
ER	39	97.5	1	2.5	40	100
VR	23	57.5	17	42.5	40	100
TOTAL	211	87.9	29	12.1	240	100

Table 1.2: Administration of proper dose of capsule

REGIONS	YES		NO		TOTAL	
	No.	%	No.	%	No	%
NR	40	100	-		40	100
BA	40	100	-	-	40	100
WR	40	100	-		40	100
GAR	31	77.5	9	22.5	40	100
ER	40	100			40	100
VR	34	89.5	4	10.5	38	100
TOTAL	225	94.5	13	5.5	238	100

Table 1.3: Post staff cuts capsule correctly.

REGIONS	YES		NO		N/A		TOTAL	
	No	%	No	%	No	%	No	%
NR	8	20	19	47.5	13	32.5	40	100
BA	40	100	-	-	-	-	40	100
WR	37	92.5	3	7.5	-		40	100
GAR	33	82.5	7	17.5			40	100
ER	10	25	30	75			40	100
VR	29	72.5	3	7.5	8	20	40	100
TOTAL	157	65.4	62	25.8	21	8.8	240	100

Table 1.4: Post staff/Attendant empties capsule completely.

REGIONS	YES		NO		N/A		TOTAL	
	No	%	No	%	No	%	No	%
NR	27	67.5	-		13	32.5	40	100
BA	33	82.5	7	17.5	-	-	40	100
WR	39	97.5	1	2.5	-		40	100
GAR	39	97.5	1	2.5			40	100
ER	40	100	-				40	100
VR	35	87.5	2	5	8	20	40	100
TOTAL	213	88.7	11	4.6	16	6.7	240	100

Table 1.5: Post Staff informed care giver child is receiving vitamin A

REGIONS	YES		NO		N/A		TOTAL	
	No	%	No	%	No	%	No	%
NR	-		40	100	-		40	100
BA	13	32.5	27	67.5	-		40	100
WR	1	2.5	39	97.5	-		40	100
GAR	4	10	36	90	-		40	100
ER	17	42.5	23	57.5			40	100
VR	8	20	32	80			40	100
TOTAL	43	17.9	197	82.1			240	100

TABLE 1.6: Post staff encourages or commends Mothers/caregivers

REGIONS	YES		NO		N/A		TOTAL	
	No.	%	No	%	No	%	No	%
NR	-		40	100	-		40	100
BA	2	5	38	95	-		40	100
WR	-		40	100	-		40	100
GAR	5	12.5	35	87.5			40	100
ER	1	2.5	39	97.5			40	100
VR	3	7.5	37	92.5			40	100
TOTAL	11	4.6	229	95.4			240	100

TABLE 1.7: Caregivers/Mother informed to return for Vitamin A

REGIONS	YES		NO		TOTAL	
	No.	%	No	%	No	%
NR	-		40	100	40	100
BA	-	-	40	100	40	100
WR	-		37	100	37	100
GAR	2	5	38	95	40	100
ER	-		40	100	40	100
VR	-		38	100	38	100
TOTAL	2	0.9	233	99.1	235	100

Table 1.8: Post Staff gave correct OPV Dose

REGIONS	YES		NO		TOTAL	
	No	%	No	%	No	%
NR	40	100	-		40	100
BA	32	80	8	20	40	100
WR	38	95	2	5	40	100
GAR	40	100	-		40	100
ER	39	100 97.5			39	100
VR	39	97.5	1	2.5	40	100
TOTAL	228	95.4	11	4.6	239	100

Table 1.9: Mothers/Caregivers Informed to Return to polio 2

REGIONS	YES		NO		N/A		TOTAL	
	NO.	%	No	%	No	%	No	%
NR	-		40	100	-		40	100
BA	18	45	22	55			40	100
WR	-		40	100			40	100
GAR	21	52.5	19	47.5			40	100
ER	25	62.5	14	35			39	100
VR	8	21.1	30	78.9			38	100
TOTAL	72	30.4	165	69.6			237	100

Table 1.10: Mothers/Caregivers informed to continue routine Immunization

REGIONS	YES		NO		N/A		TOTAL	
	No.	%	No	%	No	%	No	%
NR	-		39	97.5	1	2.5	40	100
BA	1	2,5	39	97.5			40	100
WR	-		15	37.5	25	62.5	40	100
GAR	5	12.5	35	87.5	-		40	100
ER	1	2.5	37	92.5	1	2.5	39	100
VR	13	23.5	27	67.5	-		40	100
TOTAL	20	8.4	192	80.3	27	11.3	239	100

2.0 EXIT INTERVIEWS

2.1. Knowledge of Mothers about what child received (Table 2.1,2.2):

On the whole, only about one third (36.7%) of mothers interviewed knew their child had received Vitamin A. For Polio, however, it was the reverse – about 63% of mothers interviewed knew their child had received polio vaccine.

2.2. Mother asked to Return for Vitamin A and OPV (Table 2.3, 2.4, 2.5):

When asked whether she would come back and for what only about 26.7% of mothers interviewed could say when they should return for polio 2, 3.3% could say they would return for round 2 of vitamin A and about 45.8% could say they would return for routine immunization.

2.3. Care givers/Mothers Knowledge about Vitamin A (Table 2.6, 2.7).

On the whole 21.7% of mothers could tell correctly the age groups being targeted for Vitamin A distribution. In Greater Accra Region, as few as 2 out of 40 mothers could answer this question correctly.

About half (49.6%) of the mothers could mention some benefit(s) of vitamin A, either that it saves lives, protects from illness, prevents blindness, gives good vision or that it is essential for health skin.

2.4. Mothers/Caregivers willing to come back for next dose of vitamin A (Table 2.8A, 2.8B):

For 17.5% of mothers interviewed (239) whose children ages are just around 59 months, this question was not applicable. However for the remaining 197 mothers to which the question applies, 88% would return for the next dose of vitamin A. Their major reasons for wanting to return include" to protecting child against illness"; "for the health of the child" " to ensure healthy growth of child" in that order. For the 12% of mothers who could not return, their main reason was that they were not asked to come back.

2.5. Source of information about NID (Table 2.9):

About a third of mothers (32.9%) heard about the NID from the gong gong beater, 23.7% from a health worker at the clinic or child welfare centre and 21.3% from the mobile van or public address system of Ministry of Health or the information services. Some respondent indicated that relatives or friend (19.2%) gave information about NID and 7.5% heard from the volunteer.

EXIT INTERVIEWS

TABLE 2.1 Proportion of Mothers/Caregivers aware child received VAC

Region	Yes		No		Total	
	No.	%	No.	%	No.	%
NR	3	7.5	37	92.5	40	100
BA	21	52.5	19	47.5	40	100
WR	3	7.5	37	92.5	40	100
GAR	16	40	24	60	40	100
ER	32	80	8	20	40	100
VR	13	32.5	27	67.5	40	100
TOTAL	88	36.7	152	63.3	240	100

TABLE 2.2. Proportion of Mothers/Caregivers aware child received OPV

Region	Yes		No		Total	
	No.	%	No.	%	No.	%
NR	8	20	32	80	40	100
BA	28	70	12	30	40	100
WR	20	50	20	50	40	100
GAR	38	90	2	5	40	100
ER	40	100	0	0	40	100
VR	17	42.5	23	57.5	40	100
TOTAL	151	62.9	89	37.1	240	100

TABLE 2.3 Proportion of Caregivers aware when to return for Round 2 of Polio

Region	Yes		No		Total	
	No.	%	No.	%	No.	%
NR	1	2.5	39	97.5	40	100
BA	15	37.5	25	62.5	40	100
WR	3	7.5	37	92.5	40	100
GAR	15	37.5	25	62.5	40	100
ER	21	52.5	19	47.5	40	100
VR	9	22.5	31	77.5	40	100
TOTAL	64	26.7	176	73.3	240	100

TABLE 2.4 Mothers who could say when to come for round 2 of VAC (July 2000)

Region	Yes		No		Total	
	No.	%	No.	%	No.	%
NR	1	2.5	39	97.5	40	100
BA	0	0	40	100	40	100
WR	3	7.5	37	92.5	40	100
GAR	3	7.5	37	92.5	40	100
ER	0	0	40	100	40	100
VR	1	2.5	39	97.5	40	100
TOTAL	8	3.3	232	96.7	240	100

TABLE 2.5 Caregivers could say they need to Continue with routine Immunization

Region	Yes		No		Total	
	No.	%	No.	%	No.	%
NR	9	22.5	31	77.5	40	100
BA	23	57.5	17	42.5	40	100
WR	27	67.5	13	32.5	40	100
GAR	23	63.9	13	36.1	36	100
ER	6	15	34	85	40	100
VR	20	50	20	50	40	100
TOTAL	108	45.8	128	54.2	236	100

TABLE 2.6 Caregivers aware of Eligible Target age Group for VAC

Region	Yes		No		Total	
	No.	%	No.	%	No.	%
NR	4	10	36	90	40	100
BA	7	17.5	33	82.5	40	100
WR	10	25	30	75	40	100
GAR	2	5	38	95	40	100
ER	19	47.5	21	52.5	40	100
VR	10	25	30	75	40	100
TOTAL	52	21.7	188	78.3	240	100

TABLE 2.7 Care givers that have knowledge about Supplementation

Region	Yes		No		Total	
	No.	%	No.	%	No.	%
NR	16	40	24	60	40	100
BA	17	42.5	23	57.5	40	100
WR	15	37.5	25	62.5	40	100
GAR	22	55	18	45	40	100
ER	21	52.5	19	47.5	40	100
VR	28	70	12	30	40	100
TOTAL	119	49.6	121	50.4	240	100

TABLE 2.8A Caregiver willing to return for Next VAC dose

Region	Yes		No		Total	
	No.	%	No.	%	No.	%
NR	29	72.5	11	27.5	40	100
BA	1	2.5	0	0	40	100
WR	37	92.5	0	0	40	100
GAR	34	85	6	15	40	100
ER	40	100	0	0	40	100
VR	33	84.6	6	15.4	39	100
TOTAL	174	72.8	23	9.6	239	100

Table 2.8B Reasons for coming for next dose of VAC

Region	0		1	2	3		4		5		6		Total
	No	%	No %	No	No	%	No	%	No %		No %		No %
NR			23 57.5	6 15	0	0 -	0	0 -	11	27.5 -	1	2.5 -	40
BA													
WR			- 2	- 24	-		4 1	10 2.5	- 3		7 4	17.5 10	37 40
GAR	1				4					7.5			
ER	2.5		5	7	10		1	2.5	-		8	20	39
VR	4	10	20	17	1		2	5	1	2.5	12	30	40
	6	15	50 8 20 -	5	2.5 15 37.5	12.5							
TOTAL	11	5.6	53 27	59	30	20	10.2	8	4.1	15	7.6	32	16.3	196

Table 2.9. Source of Information about Immunization (NID)

Region	1		2	3		4		5		6		7		Total
	No	%	No %	No	%	No	%	No	%	No	%	No	%	No %
NR	33		1	2		0	0	7		0	0	2	5	40
BA	82.5		2.5	5		21		17.5		-		6	15	40
WR	12	30	2	5	12		52.5		12	30	1	2.5	15	40
GAR	21	52.5	6	15	30		2	5	6	15	1	2.5	37.5	40
ER	-		9		9		13		14	35	-		4	40
VR	-		22.5		22.5		32.4		6	15	16	40	10	40
	13		28	70	14	35	9		1	2.5			4	
	32.5		5		3		22.5						10	
			12.5		7.5		12	30					12	30
					1									
					2.5									
TOTAL	79	32.9	51	21.3	41	17.1	57	23.7	46	19.2	18	7.6	43	17.9	240

CODES FOR RESPONSES FOR QUESTIONS 28B AND 29

Q. NO.	REASON FOR WILLINGNESS TO RETURN FOR VAC ROUND 2.	CODE
Q28.B	No reason/No response	0
	For health of child/Good for child	1
	To protect child against illness	2
	To ensure healthy growth of child/so child grows well	3
	Was asked to come	4
	Was not asked to come	5
	Others	6
	Sources of Information about NID	
Q 29	No Response	0
	Gong gong beater/Town crier	1
	Mobile/Van/Public Address System	2
	FM/Radio	3
	Health worker/CWC/Clinic	4
	Friend/Husband/Other relation	5
	Volunteer	6
	Others	7

SUB-NID IN NORTHERN REGION

1.0. OBSERVATIONS

1.1. Capsule Administration:

In all the 40 observations made, the child's age was determined before administering the vitamin A capsule.

Giving correct dose:

Providers were also observed giving the correct dose of capsule, that is one blue capsule for children 6 – 11 months, and one red capsule for children 12 – 59 months.

Cutting capsule correctly:

In 87.2% of observations made the capsule was cut correctly. The capsule also appeared emptied in all cases in which capsule was cut. In about 30% of observations the child swallowed the capsule whole.

1.2. Information given to mother:

No mother was told that child is receiving vitamin A in all the observations:

Only 2 out of 40 mothers (5%) were told something positive commended or encouraged to bring child for NID.

Tell mother when to return.
None of the 40 mothers was told when to return for the next dose of vitamin A

1.3. Giving correct dose of Polio vaccine:
In all 40 observations, the right dose that is, 2 drops of vaccine, was given to each child.

1.4. Mother told to return for polio 2 routine immunization:
None of the mothers was told to return for Polio nor were any of them encouraged or reminded to continue with routine immunization.

2.0. Exit Interviews (SubNID)

2.1. Knowledge of Mothers about what child received
Of the 40 mothers interviewed, only 7.5% could say that the child received vitamin A. A higher percentage, (52.5%) of mothers could say the child received the polio vaccine.

2.2. Caregivers/Mothers asked to return for round 2 vitamin A:
No mother was asked to come back for Polio or for round 2 of vitamin A and only 2 mothers out of the 40 could say they have to continue with routine immunization.

2.3. Caregivers/Mothers Knowledge of VAC distribution:
In all, 15% of mothers could say which children are eligible for VAC distribution. The remaining mothers had no idea.

Out of the 40 mothers interviewed, 65% could say correctly the benefits of vitamin A.

2.4. Caregivers/Mothers willing to return for VAC:
Almost all mothers interviewed (97.5%) will return for the next dose of vitamin A in order to protect the child from illness/for health of the child

2.5. Source of information about NID:
About 68% of mothers heard about the NID from the mobile van or public address system of the Ministry of Health or the information services van. About 27.5% of respondent indicated hearing about it from the volunteer manning the centre and the rest from either the local FM station or National Radio or from a health worker she came into contact with.

DISCUSSION

The results from the six regions have shown that generally there is little or no communication between health service providers and care givers of target children during immunization. Apart from asking questions to determine the age of the child before dosing, which the data indicates was done by almost 88% of providers, there was little communication to inform caregivers what child was being given, or a reminder return for second round to of VAC or OPV. Less than 18% of providers informed caregivers the child had been given vitamin A and on only 4.6% received any form of Commendation or encouragement for bringing the child. Concerning capsule handling and administration it was observed that majority of providers (94.5%) gave proper age-specific dose to children and over 88% emptied the capsule completely (Tables 2 & 4). However, only about 65 % of post staff were observed cutting capsule correctly as shown in table 1.3.

Communication with care givers concerning OPV immunization showed a similar trend as only 30 percent of caregivers were informed to return for polio 2 and less than 9% were reminded to continue routine immunization respectively (Table 9 and 10)

The result of the exit interviews confirmed the trend in practice observed at the immunization points. Only 36.7% of caregivers reported they are aware their wards were given VAC and 62.9% indicated that their children received OPV as shown in Table 2.1 and 2.2.

Knowledge about the NID activities among mothers/caregivers was very low even about Polio Immunization, which has had a more intensive awareness creation component. Less than a third (26.7%) could say they have to return for round 2 of polio and only 3% were aware of the second round of Vitamin A capsule distribution in July 2000.

About 50% of caregivers could mention some benefits of Vitamin A Supplementation (VAS) although close to 73 percent showed willingness to return for the second dose.

The fact that some of the caregivers know about Vitamin A and considered it beneficial is positive for behavior change campaign. In addition a large proportion of the caregivers are willing to come for second round of distribution in July 2000 despite the large information gap indicated by the results.

However, the results from the observation and exit interviews of caregivers about provision of information about benefits and attitude to giving commendation and reminders raise very pertinent training questions. The question that comes up is how effective have training sessions been as far as providing the requisite knowledge and confidence required by providers for eliciting relevant information from caregivers and also imparting health information.

There is the need therefore to review training techniques and approaches and also intensify supervision during training and immunization activities. Of particular importance is the development of detailed and practical manuals for use at the various levels. Another crucial issue is the social mobilization component which needs to be reviewed and new strategies and approaches implemented taking into account major sources of information cited by respondent in the exit interviews such as mobile vans, Public Address System and gong gong beaters.

Conclusion:

The results have indicated that there is little or no communication between service providers and caregivers during NIDs. This is particularly so as far as giving information about what children receive, about benefits of supplements or giving reminders to caregivers. This raises pertinent training and social mobilization question that needs to be improved.

Recommendation

- National NID Technical Committee (Sub-committee) to review training techniques.
- Training manuals be reviewed and improved.
- Supervision to be intensified during training and NIDs.
- Intensive Social Mobilization and awareness creation component to be incorporated in Vitamin A Supplementation activities.
- Social mobilization strategies to support OPV immunization to be reviewed to focus more on sources of information as cited by respondent and the major channels of information.

APPENDIX A:

MONITORING ADMINISTRATION OF VITAMIN A CAPSULE AND POLIO VACCINE GUIDELINE FOR OBSERVATIONS

Section 1: Identification

1.1. Region: 1.2. District: 1.3. Sub-district:

1.4. Immunization Point: 1.5. Mother No. :

Section 2: VITAMIN A CAPSULE

ACTION	YES	NO	
2.1. Determines child's age			
2.2. Gives correct dose (One Blue capsule for chn.6 mos-11mos One Red capsule for chn. above 12mos – 59 mos)			
2.3. a. Cuts correctly			N/A
2.3. b. Empties capsule			
2.4. Tells mother child is receiving vitamin A			
2.5. Tells mother she is a good mother who is protecting her child with Vitamin A/says something positive to mother/encourages mother to bring child for immunization.			
2.6. Tells her when to return for vitamin A			

Section 3: Polio Vaccine

ACTION	YES	NO	
3.1. Gives correct dose (2 drops) (State number of drops given) ……			
3.2. Tells mother when to return for Polio 2			
3.3. Tells mother to continue with routine immunization ……			N/A

Interviewer Name: ……. Date : **……**

APPENDIX B:

MONITORING ADMINISTRATION OF VITAMIN A CAPSULE AND POLIO VACCINE GUIDELINE FOR EXIT INTERVIEWS

Section 1: Identification

1.1. Region : 1.2. District : 1.3. Sub District:
1.4. Immunization Point 1.5. Mother No. :

Session 2:
ASK MOTHER THE QUESTION IN ITALICS TO ELICIT THE INFORMATION THAT FOLLOWS:
What did your child receive?

		Yes	No
2.1.	Can say that she received Vitamin A		
2.2.	Can say that she received polio vaccine		

Were you asked to come back? When and for what?

		Yes	No
2.3.	Can say when to return for Polio 2 (19th Feb. 2000)		
2.4.	Can say when to return for Round 2 of Vitamin A (July, 2000)		
2.5.	Can say she has to continue with routine immunization		

Which age groups are being targeted for Vitamin A distribution?

		Yes	No
2.6	Can say who is eligible (age groups - 6 – 59 mos.)		

What are the benefits of Vitamin A?

		Yes	No
2.7.	Can say benefit of Vitamin A (Saves lives, protects from illness, prevents blindness and gives good vision, for healthy skin.		

Will you come for the next dose of Vitamin A? If yes ask Why; If no ask why

2.8. A	Says she will return for the next dose	Yes	No	N/A
2.8. B	State reason ……			

Where did you hear about the NID

		LIST ALL ANSWERS
2.9.	Says where she heard about distribution	

Interviewer Name: …….. Date : **……**

APPENDIX C:

LIST OF MICRONUTRIENT TEAM MEMBERS:

Mrs. Rosanna Agble
Mr. Jacob Armah
Mrs Kate Quarshie
Ms. Esi Amoaful

Analysis of Observation Reports from a Vitamin A Supplementation Campaign in Zambia

IMPLEMENTATION OF THE AUGUST 20TH AND 21ST 1999 VITAMIN A SUPPLEMENTATION CAMPAIGN: *A META-ANALYSIS OF FIVE OBSERVATION REPORTS FROM CHIPATA, KALOMO, LIVINGSTONE, LUNDAZI, AND MONGU.*

1.0 INTRODUCTION

Vitamin A has for long been on the list as a public health problem in Zambia. Vitamin A capsule supplementation as an intervention started in 1992 following a devastating drought that hit the country. At the ICN held in Rome in 1992, Zambia was among 159 countries that pledged to eliminate VAD by 2000. Since then the supplementation program in Zambia has largely taken the form of institutionally-based routine, and periodic campaigns which typically came once a year mostly through the NIDs. The rationale for the campaigns was to improve routine supplementation coverage figures which have been at 28.4%.

1.1 Presently, the vitamin A supplementation campaign is being reorganized into a systematic twice-yearly format. However, there appears to be infinitesimal information on exactly what goes on in the districts during such campaigns, district planning processes, management of the campaign, quality of the service, and the general constraints that districts have to deal with. There appears to be sheer dearth of detail on ***how*** districts, for instance, manage to achieve good coverage figures during campaigns and less during routine supplementation activities. Is it necessarily all about intensity of resource support? Consequently, there has been less clear articulation of ideas about how best to assist districts achieve their targets, especially with the current new approaches being adopted. This observation exercise of the August 1999 vitamin A supplementation campaign activities in five (5) districts may, from that perspective, be considered long overdue.

1.2 Aim and Objectives of the Observation Exercize

The overall aim of the observation was mainly to gather information to be fed into the design and development of future district capacity building programs, especially in preparation for the February and August 2000 vitamin A supplementation campaign. The key objectives were:

1.2.1 to collect information on the preparatory activities that districts did undertake towards the August 1999 vitamin A supplementation campaign.

1.2.2 to observe the supplementation campaign implementation in selected districts during the two campaign days of 20th and 21st August 1999.

1.2.3 to make recommendations, based on the information collected, for possible avenues through which districts may be helped to improve their future service campaigns, and any possible reviews of Zambia's vitamin A supplementation program or component thereof.

1.3 Districts Observed

Chipata, Kalomo, Livingstone, Lundazi, and Mongu. The first four are ZIHP/CBOH demonstration districts, while Mongu is an ordinary vitamin A focus district. Each district was visited by one observer.

A tool was developed for the exercize[i] and the observers oriented on it shortly before the August 1999 vitamin A supplementation campaign days.

1.4 Financial Resources

To meet observation exercise costs were provided by MOST and ZIHP.

1.5 This presentation is a meta-analysis of five field observation reports (written and verbal) from the five candidate districts. The meta-analysis is basically an inquisitive abridgement of the five reports. Readers are encouraged to look at the individual reports for a flavour of individual district experience. Unfortunately, two of the reports could not be annexed: Livingstone and Mongu.

2.0 **METHODOLOGY**

2.1 Data Collection

2.1.1 Semi-structured interviews with members of the district health management board on the planning process they underwent in preparation for the August 1999 vitamin A supplementation campaign. This includes the approach employed and components of activities considered.

2.1.2 Semi-structured exit interviews with caretakers at observed vitamin A administration sites, on: their understanding of the campaign, their understanding of vitamina A and its benefits, the nature of service provided to them on the campaign days focusing on hospitality and information provision by the providers.

2.1.3 Observation of the system put in place at vitamin A adminsitration sites for delivery of service on the campaign days focusing on basic structure of the delivery system, perfomance on the delivery days, and support activities by supervisors.

2.2 Observer Reporting

Was both by written narrative reports and interrogated individual verbal presentations at a group meeting between site observers and the MOST local consultant.

2.3 Data Analysis

2.3.1 First stage entailed 'hard copied' descriptive narratives by vitamin A administration site observers. Within those reports the observers were encouraged to field recommendations from their perceptive constructs based on their site observation experience and records. The purpose being to sample 'evidence-based' perceptions, from site observers, on how vitamin A supplementation programmatic issues may be approached and directed in future to improve the service.

2.3.2 The second stage entailed a meta-analysis of site reports from observers by the MOST local consultant who directed the vitamin A supplementation site observation exercise.

3.0 **FINDINGS**

The integrated approach is adopted here in presenting the site observation findings. Common and unique findings in the submited vitamin A supplementation reports from the five observed districts are presented. The findings have been clustered according to the key areas of address in the observation tool, including an integrated list of recommendations from the submitted reports.

3.1 Planning

It appears clear from the results that only one district[ii] out of the five observed districts did actually get close to laying, before hand, a deliberate supplementation campaign strategy. The observed districts may be divided into two categories: those that merely embarked on a regular form of supplementation well ahead of the two supplementation campaign days, and those that had an attempt at planning only WHEN the respective observer reported at the district. The major underlying factor behind this disposition was availability of funds to meet the perceived campaign budgetary requirements. For instance, the report from Lundazi clearly indicates:

'...the DHMT management were not prepared to start planning for the campaign without funds...Mobilization/informing of the inter-agency Technical Committee was only done when the acting director was informed of my visit and she was assured that I had some money for the preparatory activities such as district meetings'[iii].

3.1.1 Chipata started administering vitamin A on the 16th of August 1999, well ahead of the campaign days. As reported, they thought the campaign was to run for the whole week, starting Monday.

3.1.2 Kalomo, Lundazi and Mongu did not start giving attention to the exercise until the 19th August when the arrival of the respective observers in the districts helped motivate the DHMTs.

3.2 The effect on districts' enthusiasm, of non-assurance of campaign financial resources to be made available to the districts apparently diminished the districts' motivation to be systematic about their preparation for the campaign. Planning committees were not a uniform feature across the observed districts. Where they were formed only in one of those districts was the committee multisectoral in constitution. In the rest, the committees were composed of DHMT staff members only.

3.3 Almost all the districts observed did not have in their district annual plans for 1999 the vitamin A supplementation campaign activity. In Kalomo the vitamin A supplementation campaign appeared in their district annual plan within the framework of NIDs activities. In Mongu, the DHMT did plan for NIDs as one of their highlights for 1999 but did not include vitamin A supplementation in that scope.

3.4 Social Mobilisation

None of the observed districts had a deliberate social mobilisation strategy, although some of them did finally set rolling a number of social mobilization activities. These activities started on the 19th of August in the majority of districts that carried them. Chipata stands out as one district that did get close to an organised process of getting information about the campaign across the district, at least two weeks before the campaign days, using their health centres, community health workers, neighbourhood health committees, churches and local leaders. However, social mobilization activites within the district's urban centre did not start until the 19th of August.

Mongu did not carry out any social mobilization activities before the campaign, although they later extended the supplementation campaign to two weeks after the formal campaign days most probably due to the presence of the observer.

3.5 Apart from the district health system structure, other channels employed by the districts that mobilized prior to the campaign days include churches, sports events, funeral gatherings, traditional events (for instance a chief's meeting), local leaders.

3.6 Management of the Vitamin A Administration Process

In all districts observed, the administration service lines seemed to have adjusted, deliberately or automatically in response to the factor of numbers of available staff to provide the service at a particular post, and the physical space available for provision of the service. However, certain key features in the service provision system emerge characteristic, in general, in the observed districts. Below is a list that describes the overall picture across the observed districts, but does not necessarily mean that each of the districts exhibited all.

3.6.1 Administration of the 200K IU capsule was predominant due to scarcity of the 100K IU capsule.

3.6.2 Cutting of the 200K for 6-12months children was accomplished by any means available and probably convinient to the provider serving: teeth, nipping, piercing using needles, scissors.

3.6.3 In some posts, mothers/caretakers would be asked to administer to their children, after a group orientation session.

3.6.4 In other posts, providers were ignorant of the differences between 100K IU and 200K IU capsule, and they would be giving 2 x 200K IUs per child above 12 months old.

3.6.5 In certain cases, there were assumptions by supervising staff that their teams of providers had full know-how of the technical aspects and policy of vitamin A administration, when actually this assumption may have been too optimistic as the monitoring reports indicate.

3.6.6 In other instances, there was prevalent conception among providers that capsules received under the Essential Drugs Program could not be used for the August campaign - even when they were about to expire.

3.6.7 The DHMT supervised activities in the posts they could reach within available means.

3.7 Reception and Communication with Caretakers

The exit interviews with caretakers in the observed districts revealed that:

3.7.1 Caretakers learnt about the campaign through mobile public address systems, radio, television, MCH announcements at health centres, house servants, and spouses. See Table I below.

Table I: Caretakers' Sources of Information and Knowledge

	Information Source						***Understand about Campaign?***		***Know what the Child has received?***		***Know about Vit. A?***	
DISTRICT	**1**	**2**	**3**	**4**	**5**	**6**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
CHIPATA	3	3	5	2	8	-	21	0	21	0	17	4
KALOMO	2	4	3	2	2	1	6	3	8	1	7	2
LIVINGSTONE	5	7	3	6	3	1	12	7	-	-	14	5
LUNDAZI	-	-	12	2	13	-	23	3	22	4	20	6
MONGU	-	-	-	-	-	-	-	-	-	-	-	-

*KEY: **1** - TV; **2** - Radio; **3** - mobile audio van; **4** - Persoanl Relations; **5** - Health Institution/Health Workers; **6** - Posters.*

notes:

a/. Mongu did not submit analyzable information for the purposes of producing this table

b/. Most respondents indicated having received information about the campaign through more than one channel, or medium, under 'information source'.

c/. Livingstone omitted the question to caretakers about whether or not they (caretakers) know what their child has just received.

d/. The data under 'information source' merely indicates medium/channel utilization, which may be a proxy for accessibility. However, analysing for impact requires a different and probably more sophisticated survey.

e/. The figures for Lundazi under 'information source' should be read as 12, 2, and 13.

f/. This information is analysed from the data by the meta-analyzer.

3.7.2 In general, there appeared to be a high knowledge level among caretakers, across the districts, about: what the campaign was all about, what their children had just received and the benefits of vitamin A. Yet, disaggregated (by district) knowledge levels seem to correlate positively with the intensity of social mobilization and the amount of time allocated to it. For instance, Mongu which had no social mobilization activities in place by 19th August (eve of the campaign) recorded the lowest knowledge levels among caretakers. A point of interest for Communication professionals might also be that Chipata and Lundazi which mostly exploited MCH as an information source and mobile audio vans scored more impressive results.

3.7.3 In Kalomo and Chipata the calendar pre-test districts among those monitored, caretakers indicated understanding of what the calender was about and how to read it. However, most caretakers suggested that the specific week(s) of the 'campaign' within the February and August months be shaded,

rather than shading the entire month. That would enable them be as timely as possible in terms of their preparations. Shading the entire months seemed quite uncertain and not very helpful, as a reminder.

3.7.4 Apart from few individual cases, communication between caretakers and service providers over the two campaign days seemed reasonable under the circumstances. The format of that communication though was mostly at variance with expectations of the observation exercise at design. Rather than a personal interchange between the provider and the individual caretaker, most vitamin A administration posts employed the group format, where caretakers gathered in the MCH room and received a collective address.

3.7.5 No particular case among the interviewed caretakers reported inhospitable treatment by the providers over the two campaign days, although the monitor's report from Chipata noted one vitamin A administration post where a nurse 'handled clients mechanically'.[iv] As the monitor observed, the nurse provided no information to clients, did not speak to them, and paid no particular attention to the child as she administered vitamin A, until the observe intervened in a way of technical advice. Fundamentally, the apparent variance, on this particular factor, between what the caretakers reported and what the observer saw may be a reflection of an established service culture, at points within the health service system, which communities have come to accept as 'normal', hence the lack of critical discernment of the provided service by caretakers. There is definite need to probe further this phenomenon. There is also need to examine the concept of 'quality of service', within this specific context, and how to operationalise it at district level.

3.7.6 The majority of caretakers expressed their willingness and knowledge about the need to bring their children after six months. Even those cases not informed by the provider on receiving the service expressed their willingness and commitment to bring their children after six months after being educated, on the spot, by the monitor interviewing.

3.8 Data Recording

Generally, districts were forced to improvise recording documents despite being provided with a standard recording and reporting form at the July orientation meeting. Lack of financial resources meant that they could not reproduce the tally sheets in amounts enough to cover all designated vitamin A administration posts during the campaign. Most were left to improvise using NID sheets left over from previous campaigns. At community level it was common for the community health workers to use blank sheets of paper for their tallying record. Notwithstanding, there appears to be no evidence to suggest that this condition in the system did in any way compromise accuracy of information reported by the districts.

3.8 Recommendations From Campaign Observers

Below follows an integrated summary of recommendations emanating from both observations by individual observers[v] and meetings the observers held with respective district health management staff in the observed districts:

3.8.1 Enough time for preparatory activities ought to be allowed, and this includes release of resources to the districts with adequate lead time.

3.8.2 While appreciated that the approach used by NIDs in terms of resource intensity is not sustainable, districts will initially still require a sizeable amount of financial support to meet certain basic costs relating to the 'minimal' resource demands of a campaign.

3.8.3 Monitoring of vitamin A supplementation should be a continuous process rather than a 'one-off' exercise on campaign days only.

3.8.4 Districts are in need of appropriately designed orientation to afford them the capacity to systematically plan and manage future campaigns sufficiently. A manual or mini-module may be produced for the purpose. The developed guideline must include approaches for setting up cost-effective campaignstrategies at the district level.

3.8.5 A cascade model should be adopted for the orientation program where the districts, with support from the central level, will be responsible for orienting the health centre staff, who in turn will orient the community-based health providers as TBAs, CBDs, CHWs and NHCs.

3.8.6 There is need to address the 200K/100K IUs capsule availability question for the capule-cutting problems faced by the primary level health providers to be significantly minimized. For instance, questions of whether or not, and when,the using of teeth to 'cut' a capule is sanative raise critical concern.

3.8.7 Strategies must be worked out to facilitate the inclusion of vitamin A supplementation campaign activities in districts' annual plans.

3.8.8 Social mobilization at the primary level should be a continuous exercise.

3.8.9 Consideration must be given to the possibility of extending the campaign days to a week or two. This will not only help lessen work-load[vi] for the already under-staffed primary health facilities but may also assure greater coverage.

3.8.10 There is need for standardized recording and reporting formats and proforma-documents supplied to the districts in adequate amounts.

3.8.11 There is minimal collaborative effort in terms of NGO involvement at the district level, and this element needs serious attention especially during orientation. It is not absolutely certain though that it may be due to possible paucity of sensitivity among the districts, or probably the constraining conditions under which they had to work during the August round could not allow most districts to network with local NGOs. This uncertainity demands being accounted for during planning at central level.

4.0 **DISCUSSION**

What story are the field observation results actually telling **?**

Coverage reports from the districts[vii] indicate encouraging results for the August 1999 vitamin A supplementation campaign round, and the 34 vitamin A focus districts deserve a word of encouragement, and some form of reassurance. The coverage figures should also be a source of motivation and hope to program planners at the central level. Incontestably, the results were achieved under quite prohibitive circumstances. Yet, this truth exceeds the level of merely considering the constraints districts may have faced and necessarily appropriates a wholistic perspective to the national health delivery system (which districts themselves are part of) and constraining factors within it, with respect to Vitamin A supplementation in Zambia.

4.2 These systemic weaknesses translate into imperfections detected by field observers during the August 1999 supplementation round, and these deficiencies are fundamental. The lack of sensitivity to the need to plan for Vitamin A supplementation campaigns at the district level, apparent lack of widespread knowledge among primary level health workers about vitamin A administration policy, non-vitamin A accommodating HMIS, absence of a vitamin A supplementation monitoring system, delayed decision making systems and relaxed facilitation processes at the central level, are but some of the imperfections currently hounding the system. It may also be safely argued that these imperfections in the delivery system, as revealed by the August supplementation observation exercise, are not necessarily a new discovery. The August 1999 report on Vitamin A orientation meeting for DHMTs identified these and others from a participatory session with meeting participants from the districts. What seems to be strikingly emerging is that the programmatic recommendations as summarized at 3.8 above necessarily consitute the various sectors or components of what may be the vitamin A supplementation program in Zambia. One legitimate question to pose at this instance is: Do central level VAD intervention planners desire a comprehensive vitamin A supplementation strategy (or program) as long as it is germane, or favor the 'fragmented' incremental approach where defects in the delivery system are tackled as they emerge**?**

4.3 In a nutshell, these reported results from the field observations seem to be evidence of the emerging reality that the vitamin A supplementation program in Zambia may not yet be as well established as many interests would prefer.

5.0 **RECOMMENDATIONS**

That the vitamin A supplementation program may not be well established presents an opportunity for formative debate and intervention. Broad recomendations can be advanced at this stage, having closely examined results from field observations as reported:

5.1 There is need to further develop, refine and implement the vitamin A supplementation program strategy in Zambia, that was developed by local stakeholders and visiting consultants Eve Tamela and Rolf Klemm in April 1999. In responce to the question posed at the end of 4.2 above, the incremental approach is primarily reactive in character, while a well designed comprehensive strategy is proactive and probably more amenable to constructive manipulation when need arises. It is this comprehensive picture that is still largely missing probably even among program planners at the central level.

Within the framework of the design the question of whether to retain the campaign approach or work towards a better designed and organized routine supplementation program, must be addressed. The current movement towards twice yearly (February and August) rounds, *supported by the calendar*, seems a plausible idea as a better adjusted '*routine*' supplementation strategy, although will still need refining for detail. The twice-yearly supplementation strategy offers opportunity for learning and borrowing from operational strengths of both routine supplementation and the purely campaign approach[viii].

The second question relates to concerns about verticalization/non-verticalization of such a supplementation program. Although a broad subject in its own respect, whether or not the program will be seen as vertical needs to be addressed carefully in full perspective of the structure of the national health delivery system and the respective operational policies with regard to decision making/planning discretion. The policy making, central planning and program implementation levels ought to be kept in perspective. What may appear vertical at central level (in fact most programs do in Zambia), does not have to be necessarily so at district or community (implementation) level.

5.2 Within this supplementation strategy there will be need to build in a strong and active communication, advocacy and training component to organize support and resources, and update competence levels in the delivery system. At policy level, the framework at figure1.0 (below) illustrates the interconnectedness between issues identified by the field observations and the three strategies. The arrows originate from the issues detected in the districts by the observation, the mediating basic problems in the system, and to the strategies that may aid minimising or eliminating the systemic deficencies. The vitamin A program still needs to campaign for itself in order to generate significant *appreciative* interest and *confidence* in the program among policy makers (in particular), local and international partners at central level, and the primary level. But to effectively advocate will require an easily discernible program structure or system, indicating the plan and its basic operation, so that even partners will find it easy to identify their contributive role without confusion.

5.3 Observation of vitamin A administration posts in the districts during supplementation activities ought to be promoted. The exercize helps bring forth an update of key implementation problems. Beyond that, the presence of observers in the districts appeared to have worked as a positive 'stimulant' for those districts observed and further provided an opportunity for the monitors to render technical support to the districts over the two campaign days. For instance, some districts did not start any activity until the observer reached the district. The report from Chipata highlights an instance when a provider administered inappropriate doses to children until the visiting observer oriented the worker on-the-spot.

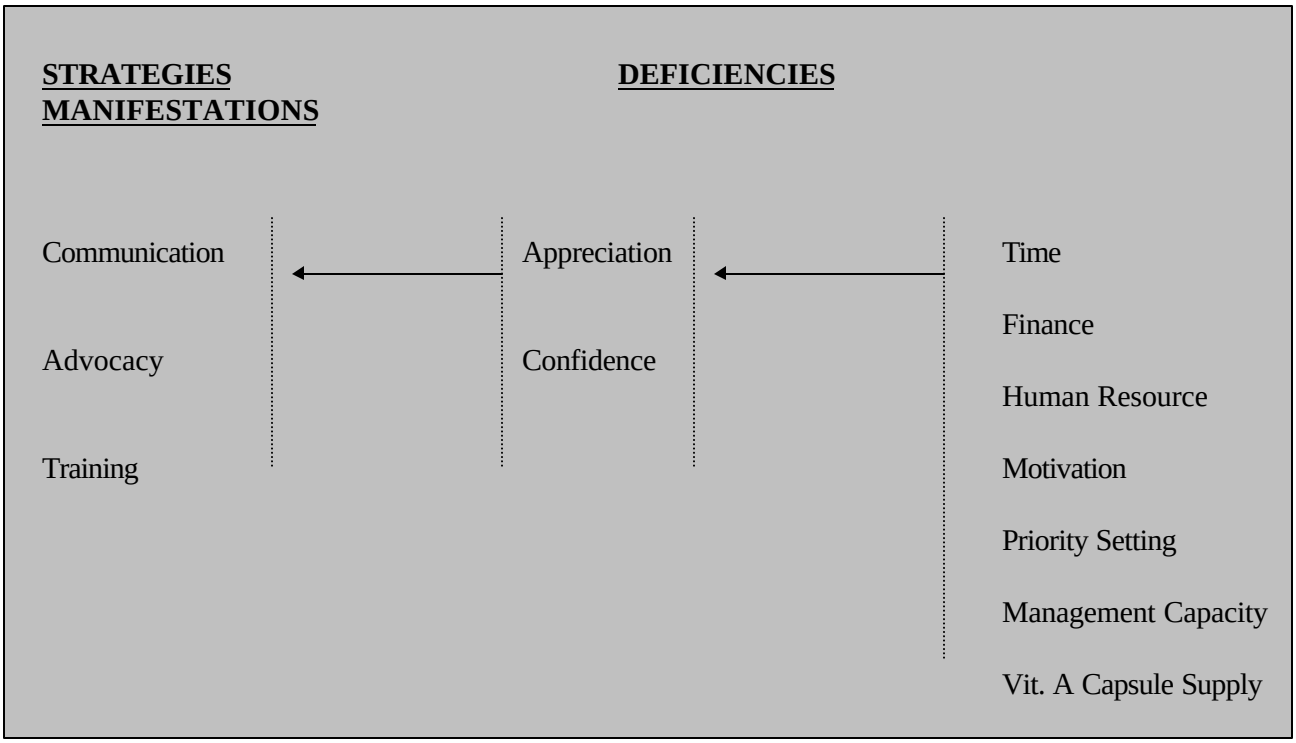

Figure 1.0

ENDNOTES

[i] See observation tool at Annex 1.

[ii] Livingstone ; It lined up three (progressively) calculated preparatory/planning meetings which seemingly enabled the district implement the campaign. What is not clear are the outputs of those (meetings), and especially the last meeting, and whether or not any supplementation campaign plan was documented (out of those meetings) in order to enable a systematic post-moterm of the activity later.

[iii] See observation report at Annex 3.

[iv] Verbal report by observer from Chipata district. Apparently the nurse is one of the provider cases that also was administering wrong doses of vitamin A to children until the monitor intervened.

[v] See field observation reports; Annex 2 to 4.

[vi] Through its distribution across a greater number of days. This systemic behaviour may be legitimately argued for;however, evidence seems to indicate that the tendency was for Vit. A administartion posts to be 'over-loaded' in the morning while be almost empty in the afternoons, to the extent where some posts would even close for the day and re-open next morning.

[vii] See coverage table by district at Annex 5. The table includes both Vitamin A focus districts and the sub-NIDs. The national averages are 68% and 84% respectively.

[viii] Latest debate surrounds the question of whether or not the twice-yearly approach should carry a campaign character. The campaign theme is getting increasingly less favoured due to expectations from districts about resource intensity levels, a legacy of the NIDs.

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ANNEX 1 OBSERVATION TOOL

AUGUST 1999 VITAMIN A SUPPLEMENTATION CAMPAIGN

OBSERVING THE IMPLEMENTATION AT DISTRICT LEVEL

1.0 **PURPOSE:**

The observation exercise intends to collect information that will highlight:

1.0.1 the nature of the campaign preparatory/planning process at the district level;
1.0.2 the implementation systems that have been set into operation for delivery of the service on the actual campaign days.
1.0.3 the quality of the service provided on the actual campaign days. 'Quality' here refers to:

1.0.3.1 efficiency and effectiveness of the delivery system operating.
1.0.3.2 interaction between the provider and the client, and how the client perceives that service.

1.1 This information will help in the interrogation and interpretation of the campaign evaluation data, including coverage results.

2.0 **AIM:**

The overall aim of the exercize is to gather information (as indicated above) to be fed into the design and development of future campaign orientation meetings or training for districts, especially in preparation for the February and August 2000 vitamin A supplementation campaign.

3.0 **OBJECTIVES:**

3.1 Collect information on the preparatory activities that districts did undertake towards the August 1999 vitamin A supplementation campaign.

3.2 Observe the supplementation campaign implementation in selected districts during the two campaign days of 20th and 21st August 1999.

3.3 Make recommendations, based on the information collected, for possible avenues through which districts may be helped to improve their future service campaigns.

4.0 **DATA COLLECTION TECHNIQUES**

This monitoring will focus on better understanding of how the districts prepare for and manage their campaigns. Data collection will be through:

4.1 observation of the vitamin A supplementation service provision on the two campaign days,

4.2 interviews with health workers probing for histiorical information on preparatory activities, and clarificatory explanantions on what is going on.

4.3 random exit interviews with clients probing for their perception of quality.

5.0 **DISTRICTS AND SITES TO BE OBSERVED**

Five districts will be observed, 4 of them being CBOH/ZIHP demonstration districts outside the NIDs, and 1 from the rest other vitamin A focus areas:*Chipata, Lundazi, Kalomo, Livingstone, and Mongu.* Each district will be allocated one monitor.

5.1 At least half of all health centres within each district urban centre and one rural outpost will be covered by the visiting observer over the two campaign days in each district.

6.0 **OBSERVERS**

The 7 observers will be selected from vitamin ATask Force member institutions and given a one day orientation on the conduct of the montioring, focusing on: *things to look for during observation, conducting interviews*, and *data recording and treatment.* The major themes to be covered will include:

6.1 entering the district/site for observation;
6.2 observation and data recording,
6.3 conducting the interviews and recording,
6.4 exiting the district/site.

7.0 **EXTRA INFORMATION - *THE PILOT CALENDAR***

Two of the seven districts, *Chipata* and *Kalomo* will receive the vitamin A calendar to be piloted. Part of the observation checklist and interview schedule will target these districts covering the handling of the calendar by health workers and its reception by caretakers.

THE OBSERVATION TOOL

A. **INTERVIEW SCHEDULE: *Planning For The Campaign By The District.***

It is critical that a minimum of three DMHT staff, inlcuding the District Director, Manager Planning and development and Nutritionist (where possible) are interviewed on the story to increase the validity of the data collected. The interview will focus on getting the ' full story' of how the district went about preparing for the campaign, probing for:

PLANNING

1.	Who was in-charge of the planning and decision making: an individual or a committee?		
2.	If it is a committee what is the composition like?		
2a.	Are there any relevant NGOs in the district? *If NO, go straight to question 3 and read it with question 2 above.*	YES	NO
2b.	If YES, were there any NGOs on the committee?	YES	NO
2c.	If Yes, list them out, *and go to question 2g below.*		

2d. If No, were they consulted? YES NO

2e. If they were consulted, why could they not participate?

2f. If they were not consulted, why not?

2g. Quantify the type of resources contributed by each participating NGO in terms of:

* Human Resources
* Finance
* Materials

3. How many times has the committee met?

4. If an individual, what is his position in the district?

5. If an individual how was decision making and delegation of duty done?

6. Was this campaign included in the 1999 district health plan?

6a. If NO, why not?

SOCIAL MOBILIZATION

7. Did the district have any social mobilization activities?

8. If yes, what were these activities?

9. If No, how did they manage to inform the local communties?

9a. Were any local organisations involved in the mobilisation process?

YES NO

9b. If YES, list them out.

9c. Were community health providers like CHWs, TBAs, NHCs involved?

YES NO

9d. If YES, indicated the list of areas or approximate numbers, or as percentage of overal district catchment.

10. Were there any special strategies for the hard-to-reach or high rsik groups?

YES NO

11. If Yes, what were the activities?

HEALTH CENTRES

12. Was there any deliberate plan to sensitize the health centres?

YES NO

13. If No, how else were they brought on board?

14. If Yes, how was it done?

MANAGEMENT AND PLANNING CONSTRAINTS

15. What constraints were faced during the preparatory period:

15.1 resources:

* capsules
* distribution
* district and community mobilisation
* specify any other.

15.2 organisational (organising resources)

15.3 specify any other

B. **OBSERVATION CHECKLIST: *Supplementation Delivery System In Operation*.**

The observer will focus on obtaining the full description of the operation of the service delivery line on the campaign days at the visited site in the district. Areas to highlight in the description include:

SERVICE LINE COMPONENTS

1. Supplies Centre - *where supplies are acquired/stored.*

2. Supplies Conveying System - *the feeding line between the store and the service point.*

3. Service Provision Point - *where health workers are providing vitamin A to clients.*

4. Recording System in place.

5. Communication between the components.

SOME KEY ISSUES TO LOOK FOR

6. Description of key functions of the role players in the components 1-4 above.

7. Physical distance between the components 1-3 *in qualitative terms.*

8. Coordination between the components 1-4 including time management between them.

9. Nature of communication between the components.

10. At component 3, *describe how* the health worker interacts with the caretaker/consumer of vitamin A:

10.1 Any welcoming or positive remarks?
10.2 Any questions paused to the caretaker?
10.3 Actual administration of the capsule - handling of the child and co-operation with the caretaker during administration?

(*IN PILOT CALENDAR DISTRICTS ONLY*)

10.4 Is the calendar given out to the caretaker?

10.5 If YES, any explanations to the caretaker about what is on the calendar and what it means?

10.6 Is the explanation given with consideration for the caretaker to understand, or one hurriedly? Is the caretaker allowed to ask questions?

ANY OTHER DISTRICT

10.7 Is the caretaker told anything after administration of vitamin A?

10.8 If YES, what is it about?

SUPERVISION

11. Any supervision/monitoring of health centres by the DHMT on the two campaign days?

12. If there, what is its mechanism of operation?

13. What are the supervisors/monitors looking for?

14. What do the supervisors/monitors actually do on the spot?

C. **INTERVIEW SCHEDULE:** ***Exit Interviews with The caretakers*****.**

The monitor will conduct random exit interviews with caretakers as they leave the service points. The interviews will be done in the morning, late morning/early afternoon, and towards close of the day, to control for time of day, and possible exhaustion on the part of health workers. A minimum of 15 clients should be conducted.

1. How did they get to hear about the campaign?

2. What is their understanding of the campaign?

3. Ask the caretaker whether they know what their child has just received.

4. What do they know about vitamin A *or the capsule their child received today*?

5. How were they treated by health workers?

5a. Was the health worker friendly?

5b. Did the health worker make any welcoming or positive remarks?

6. Ask the caretaker: ' When do you need to come back?'

(7. *Do they understand what the calendar says and what it is for?)*

(8. If Yes, who explained to them about the calendar?)

***(9**. If No, has really nobody ever explained to them?)*

11. Will they come back after six months? YES NO

12. If NO, why not?

13. What has been the best part of their experience of the service today?

14. What has been the worst part of their experience of the service today?

PLEASE SUMMARIZE KEY INFORMATION AS PROVIDED BELOW

15. Did the health worker:-

	YES	NO
a. Remind the caretaker to return in February		
b. Or remind the caretaker to return in six months		
c. Tell the caretaker that the child was given Vit. A		
d. Act pleasant/friendly		

D. **FINALLY: *Overall Constraints and Other Information.***

1. What major problems have constrained smooth operations in the district on the two supplemenation campaign days? *please outlie in detail especially based on your observation and probing of the situation. **Justified** analytical reasoning is also permissible. But bare facts are primary.*

2. Please obtain the following information:

   a. Availability of Vitamin A capsules in the district over the last year (*check with district pharmacy records*).

   b. Availability of vitamin A capsules in all health centres in the last year.

3. Were there any people remaining unserved at the end of the final day of the two day campaign? *Especially for the second health centre which will be covered on the second day.*

ANNEX 2 LUNDAZI DISTRICT REPORT

1.0 **Introduction**

The purpose of the exercise was to collect information on the preparatory/planning process at the district and health centre levels towards the campaign and to observe the implementation of vitamin A supplementation on the actual campaign days. The monitoring tools used were mainly observation of vitamin A supplementation service provision on the two campaign days, interviews with health workers on preparatory activities and random exit interviews with caretakers on their perception of the service. Information was also collected on availability of vitamin A at the district and the health centres over the last year and also on vitamin A coverage pre-supplementation campaign.

At least six (6) health centres were visited before the campaign days, and only had a chance of attending two preparatory meetings in two health centres. Others had their meetings a day before or an hour or so before our arrival. Observations and exit interviews were done in two health centres. One of the health centres was within the town settling, while the second was in a rural area about twenty-six (26) kilometres away from Lundazi town.

1.0 **Objectives**

The objectives of the exercise were:-

- To collect information on the preparatory activities that districts undertook towards the August 1999 vitamin A supplementation campaign

- Observe the supplementation campaign implementation in selected districts during the two campaign days of 20 and 21 August 1999, and

- Make recommendations based on the information collected for possible avenues through which districts may be helped to improve their future service campaigns.

1.0 **Planning for the Campaigns by the District**

Despite the de-briefing by the two officers who just returned from the orientation meeting held at Rimo Motel,in Kafue, the DHMT management were not prepared to start planning for the campaign without funds and they also felt that the activity was not planned for in 1999 district plan. Mobilisation/informing of the inter-agency Technical Committee was only done when the acting director was informed of my visit and she was assured that I had some money for the preparatory activities such as district meetings.

The committee managed to meet only once and I was privileged to attend. The opening remarks by the chairman were of disappointment at the abruptness of the exercise as previous exercises of this magnitude were announced two or three months in advance. Inspite of these, the committee went ahead and formed two sub-committees which were publicity and coordinating committees. The publicity committee was mandated to go flat-out in informing the public about the two days supplementation campaign and where this will be taking place. While the coordinating committee was responsible for logistics including sourcing for transport from identified organisations and government departments.

The members of the inter-agency Technical Committee comprised of mostly from government departments such as MAFF, Veterinary, Health, Community Development and the Council. Also two NGOs were in attendance and these were Clark Cotton and Lutheran World Federation (LWF). All the organisations contributed vehicles and the drivers, while the DMHT was responsible for fuel and lunch allowances for supervision.

1.0 **Social Mobilisation**

Due to delayed funds, there were no plans for social mobilization activities at the district level. I had to organise for public announcement immediately I arrived and these were conducted on two consecutive days prior to actual implementation of the supplementation exercise.

The health centres at least managed to inform the communities in good time, since they were told about the campaign three weeks in advance during the PLA training seminar for the health centre staff. All the health centres were represented except for one. To disseminate the information, the health centres used Neighbourhood Health Committees which comprise, CHWs, TBAs, Community Based Distributors (CBDs), Nutrition Clubs, Retirees Teachers and Community Leaders. They also took advantage of gatherings such as funerals, churches even chief's rally to inform the caretakers about Vitamin A Supplementation Campaign. It was very fortunate that the health centre staff from hard-to-reach areas were present at the PLA seminar as such managed to disseminated the information immediately they got back in their respective areas.

1.0 **Logistics and Distribution**

Vitamin A capsules and posters were given to all health centres staff during the same PLA training seminar except for one rural health centre which did not participate. The capsules and the posters were Airfreighted up to Chipata by ZIHP and then transported by road to all districts in the Eastern Province including Lundazi. At the health centre level, meetings were called with the neighbourhood health committee members at which they were given the materials and the capsules. Due to lack of funds no materials were produced locally only posters and guidelines produced at the central level were available.

1.0 **Availability of Vitamin A Capsules**

Apart from the supplies for the campaign, almost all health centres had no available vitamin A stock and some health centre staff did not even know where to order from even though some health centres said at times they keep some to use in treatment.

At the District hospital pharmacy, there were about 8,000 (round, yellow, 200,000 IU) capsules which they received through the Essential Drug Programme (EDP), but unfortunately, there were no stock records of Vitamin A over the last year.

1.0 **Vitamin A coverage Pre-Supplementation Campaign**

All health centres visited had no records for vitamin A coverage. The majority of the health centres confirmed giving vitamin A as treatment, some also supplemented women when they delivered but no records were kept reason being that, they had no tally and reporting forms for vitamin A. In general almost all health centres confirmed not giving A to children aged 6 months to 6 years since they did not know that they were supposed to do so.

At the district level, the only data availed to me was from January-April, 1998 and January-June, 1999 which is as follows:-

1998:	January-April	
	6-11 Months	193 supplemented
	12-59 Months	580 supplemented
	Lactating Mother	123 supplemented

1999:	January-June	
	6-11 Months	584 supplemented
	12-59 Months	1,168 supplemented
	Lactating mothers	361 supplemented

1.0 **Management**

Seventy-four (74) existing health posts were used for vitamin A supplementation campaign throughout the district. These included, health centres, the district hospital, schools and the market. At the hospital and in the health centres, nurses were tallying and giving vitamin, while community health workers were paired with other Neighbourhood Committee members at various posts. Everybody involved in the exercise had prior knowledge on how to administer the correct dosage according to age category.

Observations at the two posts (health centre and a school) I visited showed that, health providers were using scissors to nip-off the neck from the capsule and squeezing out the content into the children mouth whether very young or old enough to chew.

It was also observed that, there was good turn-up from early morning up until mid-day when only one or two clients showed-up at an interval of 5-10 minutes. At 14:30 hours, caretakers started coming in numbers again until about 16:00 hours when there were no more clients coming. In some posts when the turn up was very low especially in the afternoon, health workers went door to door to give Vitamin A.

Most children were brought in by their mothers while others were brought in either by the fathers, maids or older siblings.

It was further observed that, posters and guidelines provided to health centres were not displayed any where around the surrounding areas. These were only seen displayed inside the clinics or laid on the tables used by health workers during the supplementation.

1.0 **Exit Interviews**

During the exit interviews, the majority of the caretakers expressed happiness that their children received vitamin A. It was satisfying to note that, most caretakers interviewed at least explained that when a child received vitamin A, it will be protected against diseases and from going blind, even though some could not say what kind of diseases. For those who were told to come back in six months for another dose of vitamin A they enthusiastically said that they will definitely do so because they want their children to stay healthy.

When asked about from where they heard about vitamin A campaign, the majority said that they heard about it from the health workers when they took their children to under-five clinics. Some heard from friends who went to under-five clinics, others from the neighbourhood health committee members, at a funeral gatherings and churches, while those in urban (town) setting said they heard from the public announcements, or were informed by their maids and husbands. One or two caretakers said that they heard from the radio.

1.0 **Supervision/Monitoring**

Members of the Technical Committee supervised the supplementation of vitamin A at various posts. Five vehicles and two motor bikes were mobilized for the exercise. Supervisors were assigned to different areas each, and a vehicle was allocated to three or four supervisors, these were dropped at various posts in the morning and were then picked later at the end of the day. The task of the supervisors was to see to it that, there were enough stocks of vitamin A capsules at each post. Supervisors were supplied with extra stocks of vitamin A capsules in order to replenish where stocks ram out.

They were also monitoring the administering of vitamin A to children and how they were tallying. If they observed that these were not done correctly, their task was to show the providers the correct way of tallying and administering the correct dosage according to age group. In some cases they had to help in the giving of vitamin A or tallying where they found that the CHW was overwhelmed with the turn-up. They were also supposed to collect data at the end of each day, unfortunately this was not possible since most posts were unable to compile by the time the supervisors were leaving.

1.0 **Identified Problems/Constraints during the August Campaign**

11.1 **Vitamin Capsule Availability**

On the first day, all posts had adequate stocks of vitamin A, but on the second day, a few posts run out the capsules due to lack of extra stocks. The contributing factor identified was because of lack of 100,000 IU capsules which were supposed to be given to the 6-11 months olds as such, the 200,000 IU were used squeeze out half the content of the capsule for the under one year olds, then the other half was either thrown away or forgotten to be given to the next child.

Some CHWs even health centre staff had problems with cutting or nipping-off the neck from the capsules. Supervisors found out that some people had no scissors or razor blades for cutting as such, some used sharp objects like thorn, needles even sharp and strong grass. In one or two places, they found the staff using their teeth, while others gave the capsule to the caretakers and told them to nip-off the neck using their teeth before giving it to their children.

11.2 **Distribution of Logistics**

Lundazi district in general had no problems in distributing the capsules as well as other materials because health centre staff got them during the PLA training seminar. All the logistics were distributed at the end of the seminar and in turn, the neighbourhood committee members collected all the requisites when they met during the preparatory meetings.

The only problem was that the materials especially the posters were not enough and a few posts were given only one of the posters instead of having a set of a boy and girl posters. As for guidelines, these were only adequate for health centres and not at the posts in the communities.

11.3 **District and Community Mobilisation**

At both district and community levels, no promotional activities were conducted due to lack of funds. The district was only prepared to plan for the campaign when the funds were made available for the exercise. They also felt that the activity was to abrupt and it was not featuring anywhere in their 1999 district plan.

Even though we managed to conduct public announcements on my arrival for two consecutive days, these were only beneficial to people within the surrounding areas near town, and this kind of activity needed to be done at least one to two weeks in advance not only for two days as was the case.

11.4 **Transport Mobilisation**

Due to lack of adequate funds, only a few vehicles were mobilised for supervision. This made it difficult to monitor the hard-to-reach areas in the valley. Inadequate fuel allocation also made it impossible to monitor/supervise some sites in certain vast areas.

11.5 **Lunch Allowances**

This was a big issue especially with the members of the neighbourhood committee. Despite the explanations that they were supposed to work on voluntary basis, some still felt that, they needed to be given something. Because it was unhealthy and very difficult to work on an empty tummy from dawn till dusk. Supervisors were told to inform the organisers/planners of such marmoth task to consider provision of lunch allowances in future campaigns.

12.0 **Recommendations**

12.1 The Future Vitamin A Supplementation Campaigns should be the Integral part of the district health plan in the year 2000, and should also be accorded the importance it deserves.

12.2 Organising committees should secure enough funds and other resources for proper planning, social mobilisation and actual implementation of February and August 2000 campaigns.

12.3 Enough time should be allocated to promotional activities, and adequate promotional materials need to be produced to cover all areas.

12.4 It was also felt that, social mobilisation should be an ongoing activity and only needs to be intensified two weeks prior to the implementation of the campaigns.

12.5 It was further recommended that, activities of this magnitude and importance should be allowed to run for a week not only for two days as was the case with August supplementation campaign.

12.6 There is great need to orient the DHMT management and health providers at all levels on the vitamin A supplementation campaigns management and Vitamin A supplementation program in general.

12.7 It was strongly felt that 100,000 IU vitamin A capsules or liquid vitamin A with dispensers should be made available during February and August campaigns in the year 2000, to ease the problem of cutting and squeezing the correct dosage for the 6-11 months olds from a 200,000 IU Vitamin A capsules.

12.8 There is also great need to call a seminar for health centre staff in order to orient them on the importance of vitamin A supplementation acquisition of the supplies, tallying and record keeping and reporting.

12.9 Monitoring of vitamin A supplementation programme should be an on-going process by the district level staff rather than only during the campaigns.

13.0 **Conclusion**

Despite inadequate funding, delayed funds, short notification about the campaign and less commitment by the DHMT management, the health centre staff went flat-out to prepare for the exercise. I wish to commend the health centres and the MCH staff for their dedication for the successful implementation of the August campaign in spite of very limited resources especially funds. My sincere gratitude also goes to the district inter-agency committee for their swift action in organizing the necessary resources especially vehicles and human resources to help in the monitoring of the exercise. Last but not the least, I am grateful to ZIHP for the support torwards making the August campaign monitoring exercise happen. To you all I say, WE DID IT!!

ANNEX 3 CHIPATA DISTRICT REPORT

1. **Introduction**

The trip was undertaken from 16 to 23 to monitor district preparations for August 20 and 21 Vitamin A supplementation to Children 6 to 72 months. However, upon arrival in Chipata it was learnt that the district had actually started giving vitamin A to children on 16/08/99 until 21/08/99. As such my programme had to fit in the DHMT monitoring schedule which they had prepared for the Campaign week. During the visit attention was paid on monitoring process of administering vitamin A to Children, stocks of vitamin A and, coverage as per day of visit, and how mother/caregivers/community were mobilised. In addition pre-test on the vitamin A supplementation calendar was done at four health facilities.

2. **Objectives**

The trip was undertaken to meet the following objectives:

2.1 Improve accessibility and availability of vitamin A for supplementation to children 6 months to 6 years.

2.2 Observe the availability and distribution of vitamin a at district, Health Centre and community levels.

2.3 Observe the involvement of NGOs and communities in the vitamin A supplementation campaign.

2.4 Prepare/develop background information for future plans for vitamin A activities.

3. **Process**

The first day (17/08/99) a brief meeting was held with the Deputy Director Administration (Mrs Chama) and the PHN (Mrs Musukwa). At this meeting it was learnt that Chipata district began the Vitamin A campaign week on 16/08/99 up to 21/08/99.

A team of 5 was instituted to supervise and monitor the supplementation at the health centres. These included three from the DHMT i.e. DDA who was actually acting District Director of Health, the PHN (Mrs Musukwa), and the Nutritionist (Mr Siachalinga), and the Provincial Nutritionist (Mr Chirwa).

The team divided into two groups each visiting several centres in a day. The team was oriented to the monitoring tool. Each day in the morning before departure to the field the teams met at the DHMT to share experiences from the field, took remedial action were need arose, and collected more vitamin A especially the 100,000 I.U. capsules which were not readily available at most of the health centres.

At each HC the monitoring teams checked on vitamin A stocks, observed actual practices on administration of vitamin A, and how mothers/caregivers were received and attended to. In addition observations were also made on recording of data. Advice was given where appropriate with clarification on the purpose of the campaign.

Exit interviews were conducted with caregivers at 5 health centres i.e. 2 urban and 3 rural. These were randomly selected from the list of 27 HCs. In addition calendars showing vitamin A campaign weeks was pre-tested among the caregivers after their children received vitamin A.

Discussions were also held with health centre staff on how they mobilised communities, problems/constraints encountered and issues to consider for planning for February 2000 campaign.

Two vehicles were mobilised, one from the District Health Management Team (DHMT) and the other from Provincial Medical Officer's (PMO) office. During the visits some health centres were assisted with fuel to enable them reach some distant places in their catchment areas.

Out of 27 Health Centres, 21 were covered during the campaign week. However, the district planned to visit the other 7 centres even after the campaign week.

4. **Outputs/Outcomes**

Mothers/Caregivers Knowledge on Vitamin A

From the 21 caregivers/mothers interviewed all of them stated they knew what their children had received i.e. vitamin A. About 17 of them tried to explain the importance of vitamin A as necessary for disease prevention and keeping children in good health and growth. The other 4 did not had about importance of vitamin A although they brought forth their children to receive the VAC.

4.2 Availability of Vitamin A

The DHMT had distributed vitamin A mainly the 200,000I.U to all the centres before 16 August 1999. This was mainly the recent stock supplied for the awareness campaign week. However, a about 8 Health Centres had ample vitamin A capsules that they obtained through the EDP which could have actually met their requirements for this month's campaign. Apparently some capsules from EDP/IDA were expiring August and September 1999. In such cases the staff were advised to utilise old stock first.

Few health centre had the 100,000 I.U capsules which was however plenty at the PMOs office (about 260,000 capsules). This was left over stock from last year's NIDS. As such during monitoring these were supplied to most of the health centres to cover even for February 2000 campaign (See appendix I for vitamin A stocks).

4.3 Mobilisation for Vitamin A Awareness Campaign

Since funds for the campaign were delayed Chipata DHMT decided to go ahead with the campaign using the little resources they had at that moment. A week prior to 16 August, a circular was sent to all Health Centres informing them of the campaign and asked them to use CHWs, TBA, Neighbourhood Health Committees, Churches and local leaders to publicise to the masses.

In addition at community level announcements were made during funerals, at church gatherings, at traditional ceremonies, and football matches.

Health centre staff also sent word of the campaign through clients at OPD, mothers/caregivers attending under five and antenatal clinics. Some caregivers interviewed state that they also got the message on ZNBC Radio 2 and television, while others heard from friends and relatives (see Appendix V)

However, some HCs feared that their coverage would be low because they did not publicise adequately due to short notice and lack of resources to cover more areas in their catchment areas.

The DHMT could institute a task force because they felt there was insufficient time. As such they decided to use health and community structures to mobilise the people for the campaign. However, NGOs like ADRA from Mwami Hospital, and LWF were involved in disseminating information on the campaign in their areas of operation. ADRA took part even during the campaign week in giving vitamin A and supporting HCs in their project areas to reach even difficult areas.

4.4 Administration of Vitamin A at Health Centres and Community

At most of the HCs nurses were giving Vitamin A. Observations at two centres showed mistakes in giving doses to children 6-11 months who were mistakenly given 200,000 I.U. instead of 100 I.U. (that is half drop of the 200,000 I.U). At one centre the nurse did know about vitamin A dose as indicated on the bottle, as she never bothered to read it other than just knowing the contents to be vitamin A.

At most of the centre due to inadequate staff CHWs, TBA, Community Based Distributors, and some members of the NHCs were utilised to give the vitamin A capsules to children at the HC. Most of them were however not properly instructed on how to cut the nip off the capsule because some cut the nip off using their teeth. However, others were merely twisting the nip off.

At one centre there was only one trained staff to give vitamin A as well as vaccines. Due to high workload she just demonstrated to mothers/caregivers how to cut off the nip and squeezing the capsule into the child's mouth and gave the mothers capsules to administer to their children. Observations showed that mothers/caregivers did it correctly and there was less noise from children than when the nurse was administering.

Other centres gave vitamin A to CHWs, TBA, CBDs and some NHC members who went to their respective catchment areas to give vitamin A. They returned to the clinic for replenishment of stocks and submission of tally sheets.

4.5 Recording Data

Since the district did not have funds to reproduce the tally sheet which they got from the one day meeting in Kafue, they had to improvise by using the NIDs tally sheets on which the just inserted the 60 to 72 months on the section for OPV. Where these were not available CHWs, TBAs, CBDs and NHC used blank sheets of paper where they marked strokes of five just like the zeros on the tally sheet. Observation showed that CHWS, and CBDs were able to record properly on the tally sheets.

4.5 Pre-testing Calendar

Almost all the caregivers interviewed indicated that they understood what calendar says and the purpose. They stated that the health workers explained it t them. Some suggested that the weeks for the campaign should be highlighted within the months of February and August. Two CHWs and CBDs supported the idea.

4.6 Vitamin A coverage Supplementation

4.6.1 Pre-supplementation Coverage

Data was not available for the routine supplementation except for NIDs data for 1998.

4.6.2 August 1999 Coverage

By 21 August most of the Rural Health Centres had reached above 50% coverage. The two urban clinics Kapata and Chizongwe had very low coverage due to delay in publicity as they were waiting for the PA system, which was promised to them by Zambia Information Services at no cost. Although drama was held at three markets, turn out was still low by 20th August. Since the two clinics have a higher target group, the DHMT decided to extend supplementation period up to about 25 August.

4.7 Major Problems/Constraints

4.7.1 Non availability of funds resulted affected the DHMT in the following:

- Low mobilisation of communities for the campaign.
- No orientation of HC staff and community health providers/volunteers on the campaign.
- Could not reach some HCs to deliver vitamin A and information about the campaign.
- Could not reproduce enough tally and report forms.
- Could not manage to constitute the Vitamin A Campaign Taskforce or even to utilise the NIDS Committee.

4.7.2 Non availability of 100,000 I.U. Vitamin A capsules. These were however plenty at PMOs Office which remained from last year's NIDs. Most of the DHMTs in the province were informed about it but could not collect it for reasons better known to them.

4.7.3 Guidelines for the campaign were not made available to the HC staff. This resulted in poor quality of the service at most of the centres. At some centres doses of vitamin A were not given correctly according to age even by some qualified staff and community health volunteers.

4.7.4 Vitamin A awareness campaign was not included in the district action plan as such was not given priority until after the orientation meeting held in Kafue for Non-NIDs districts.

5. **Conclusion And Way Forward**

Chipata DHMT deserved a part on the back for having taken up the initiative to start the campaign even without funds from Lusaka. The structures at community level proved useful in view of inadequate notice and resources to

mobilise the masses for the campaign. At least more than 60% coverage is anticipated. However a number of weakness need to be addressed especially towards planning for February 2000 campaign. Some immediate actions required should include:

1. Funds that were released for preparatory activities for the campaign should be used to hold a one-day meeting for HC staff to reorient them on the campaign. The meeting will also review their performance during the August campaign and chart the way forwards towards the February 2000 campaign.

In turn HC staff should be allocated some funds to hold one day meeting for their CHWs, CBDs, TBAs and NHC who were involved in the campaign especially to orient them on administration of vitamin A.

2. A task force should be constituted if Non-existence. However, if the NIDs committee exist, it should be transformed into the vitamin A task force. The DHMT should include key NGOs into the committee such as ADRA, WVZ, LWF, Moslem Community etc. A meeting should be called within the next two weeks after the campaign to share experiences highlighting major weaknesses that should be taken care of during planning for February 2000.

3. Social mobilisation for February campaign should be a continuous exercise using all possible means. The pre-test results for the calendar should be reviewed immediately so that more copies are produced and distributed throughout Zambia.

4. Soon after the campaign the District Nutritionist should conduct audit for vitamin A capsules in order to assess adequacy of stocks and prepare for restocking in readiness for February campaign.

5. The Vitamin A campaign weeks for February and August 2000 should be included in the district annual action plan. The National Vitamin A Task Force should finalise, produce and distribute guidelines for conducting vitamin A awareness campaign.

ANNEX 4 KALOMO DISTRICT REPORT

The Objectives

1. To collect information on the preparatory activities that districts undertaken towards the August 1999 "Vitamin A Supplementation Campaign".

2. To observe the Supplementation Campaign implementation in selected districts during the two campaign days of 20 - 21st August, 1999.

3. Make recommendations based on the information collected for possible Avenues through which districts may be helped to improve future service campaigns.

Planning

The planning for the District Vitamin A Campaign was done on the 12th of August 1999 by the DHMT Mother Board which was composed of seven (7) members. Their names are listed below:

NAME		**POSITION**
Mr. K. Keyana	-	District Director
Mr. V.S. Sichilongo	-	Manager, Administration
Mrs. R.K. Zimba	-	Planning Manager
Mrs. V. Siyanzila	-	MCH Co-ordinator
Mr. M. Sikute	-	District Health Inspector
Mr. C. Kanchele	-	District Accountant
Mr. Chambwa	-	Environmental Health Technologist

The August 1999 Vitamin A Campaign was not included in the Plan. It was only included as NIDS for 1999.

Records At The Pharmacy

Kalomo District Hospital Pharmacy had the following stock level.

Stock received on 20th May 1998 - 20,000 (200,000 Iu)

Balance at hand on 18th August 1998 - 6,000 (200,000 Iu)

Stock utilised was - 14,000 (200,000 Iu)

The above stock was utilised in 1 year 3 months.

Social Mobilization

Kalomo District had some mobilization activities and some of them were Drama Groups, Poetry Narrating, Mobile Campaign using a loud speaker.

The Drama Group was called Mwata Uprising Theatre Club and they were to perform on the two campaign days.

The community Health Providers like the CHWs, TBAs, NHCs were included in the Vitamin A Supplementation Campaign. They were informed on the 16th of August 1999. Posters and Vitamin A capsules were also distributed to all Rural Health Centres accordingly.

A Time Table was drawn and members of staff at Kalomo DHMT and Hospital MCH members were sent in different Health Centres to cover the two campaign days.

Hondas and bicycles were used in the hard to reach rural health posts. Some of the Rural Health Centres in Kalomo District are Kasukwe, Nakatala, Bulwibendo, Chenzya, Omba, Mila-Male, Kandanzau, Habulungu and Shamba.

The above rural health posts combined MCH routine activities with Vitamin A Supplementation from the 10th - 17th August, 1999.

Management And Planning Constraints

1. The financial support was not received on time, as a result there were a lot of problems in terms of transport, allowances for lunch and the overall organization of the 3campaign was adversely affected.

2. The Vitamin A capsule was not distributed in good time hence some Rural Health Centre had to use their old stock Vitamin A capsule.

Observation

The first Campaign day was done on 20th August 1999 at Kalomo District Hospital and the people involved in the supplementation were only two (2). a) Nurse and b) MCH Co-ordinator

- All supplies were got from the Pharmacy by 08.00 hours.
- they were 200,000 Iu and 100,000 Iu Capsules.
- the arrangement was like that of an MCH Clinic with benches surrounding the table.
- All Vitamin A Capsules and Recording Sheets were on one table.

- At the service provision - point (where the health workers are providing Vitamin A to clients) the health worker welcomes the client, no questions are paused to the care taker and Vitamin A Capsule is given to the caretaker so that she/he gives the child.
- Some only sent their children for the Vitamin A Supplementation.
- The Vitamin A Capsule was being given to the child without cutting due to lack of equipment.
- The Nurse was leaving the service point frequently so the clients had to wait for her.
- The turnover was very good from 09.30 hours until 13.00 hours, by mid-day there were very few clients.
- No information was stuck on notice board to note that it was Vitamin A Campaign Day.

Second Day (21st August, 1999)

- The first client came around 08.00 hours at the Second Health Post on the 21st August, 1999.
- There was good attendance as compared to the First Health Post.
- The flow of clients was even throughout the day, and the last client was attended to around 17.30 hours.
- There were two (2) health workers at the Second to Health Post.
- The Nurses were quite friendly and never left the post frequently.
- Questions were paused to caretakers with good explanations of the campaign.
- The Vitamin A Capsule was cut with a razor blade.

Pilot Calendar

The Calendar at the First Health Post is given to the caretaker with a brief explanation as compared to the Second Health Post where the Nurse explains the importance of the Calendar to the caretaker and given time to ask questions.

Supervision

The DHMT monitored the Campaign days and supervised the staff under them. The supervisors were checking on attendance at the different health posts, number of staff at each health post and if they were competent with their work, thy also ensured that the supplies of the Vitamin A Capsule was adequate.

Random Exit Interviews With Caretakers

A total number of 30 people were interviewed on the First and Second Campaign days. The following were the categorized results for the different questions paused to the caretaker.

1. How did they get hear about the campaign?

   A total number of 20 caretakers heard about the campaign on the radio.

   - Seven (7) heard from the loud speaker through the Department of Information Service.
   - Three (3) heard from their husbands who are Community Health Workers.

2. What is their understanding of the campaign?

- Seventeen (17) caretakers said the campaign was to prevent other diseases.

- Eight (8) caretakers said to protect against bad eye sight.

- Three (3) said they did not know.
- Two (2) said that to prevent diarrhoea.

3. When the caretaker was asked what the child had received:

   - 25 said it was Vitamin A.
   - Five (5) said that they were well treated by health worker.

4. When asked how they were treated by health worker:

   - Thirty (30) caretakers said that they were well friendly and made positive remarks.

   - Five (5) said that they were treated by health worker.

5. When asked when they need to come back:

   - Twenty-six (26) said in February 2000.

   - Four (4) said they did not know.

6. When asked about the best experience of the service, 30 caretakers said that because they have been given calendar to remind them when to come for the next dosage.

Recommendations

1. The 2000 Vitamin A Campaign has to be planned in such a manner that all the Financial Support is given a month before the actual campaign days.

2. There is need to strengthen nutritional advocacy at CBoH/MOH level through District Planning Channel. CBoH also to be sensitized on the Vitamin A Supplementation.

3. Vitamin A should be one of the priority in the health action plans.

4. A Continuous Orientation Training Programme should be put in place for all districts in the country.

5. It is important to monitor the Vitamin A 2000 Campaign especially after the Orientation Training Programme, for all health centre staff in the country.

ANNEX 5 **COVERAGE RESULTS**

Coverage Results for Vitamin A Supplementation (Non-NIDS districts).

Province	District	Target Population	No. Supplemented	%Coverage
Central	Chibombo			
	Kapiri-Mposhi			
	Mumbwa			
Copperbelt				
	Mpongwe	2,741	947	35%
Eastern	Chadiza			
	Chama			
	Chipata	57,859	37,734	65%
	Katete	35,537	27,187	75%
	Lundazi			86%
	Mambwe	10,800	4,859	62%
	Nyimba			
	Petauke			
Lusaka	Chongwe	22,119	14,605	67%
	Kafue	33,094	13,887	45%
Northern	Chilubi	8,638	6,136	71%
	Nakonde	12,426	10, 043	80%
	Mungwi	22,242	13,519	60%
	Luwingu	14,988	12,703	85%
North-Western	Kasempa	8,991	4,143	46%
	Mufumbwe	6,242	3,998	64%
Southern	Choma			
	Kalomo	35,770	28,230	79%
	Kazungula	15,798	8,993	56%
	L/Stone	18,118	15,885	88%
	Mazabuka			
	Monze	43,388	25,334	58%
	Namwala	15,300	11,741	78%
	Siavonga	11,696	6,319	54%
	Sinazongwe	21,571	12918	60%
	Itezhi-Tezhi	7,200	5,545	77%
Western				
	Kaoma	28,537	23,697	82%
	Mongu			
	Senanga	20,991	13,258	63%
	Lukulu	11,243	11,698	104%

Total Coverage **68%.**

Coverage Results for Vitamin-A Supplementation: (SUB-NIDs Districts 1999)

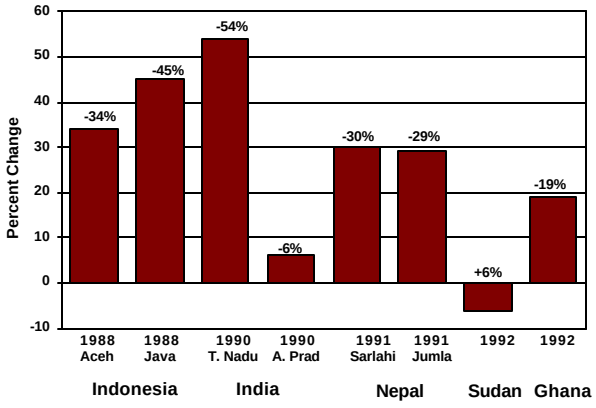
Province	Dictrict	Children 6-11 months	Children 12-59 months	No. Supplemented 6-11 mths	No. Supplemented 12-59 mths	% coverge 12-59 mths
Central	Mkushi	3,102	24,816	3,587	20,629	87
	Serenje	3,242	25,938	2,938	18,578	74
Copperbelt						
	Chililabombwe	1,355	10,839	1,943	11,327	109
	Chingola	4,074	32,594	5,248	34,742	109
	Kalulushi	1,596	12,767	2,171	10,832	91
	Kitwe	10,861	86,888	11,633	59,698	73
	Luanshya	3,353	26,827	3,473	25,889	97
	Lufwanyama	1,214	9,714	1,546	9,665	103
	Masaiti	1,985	15,882	3,494	15,406	106
	Mufulira	4,822	38,573	4,091	32,701	85
	Ndola Urban	9,837	78,696	10,713	75,325	97
	TOTAL	39,097	312,780	45,633	279,624	92
Luapula	Chienge	1,422	11,375	3,600	13,659	135
	Kawambwa	2,136	17,088	3,742	13,766	91
	Mansa	4,665	37,318	7,091	30,057	88
	Milenge	857	6,854	831	6,765	99
	Mwense	2,048	16,382	3,793	17,317	115
	Nchelenge	3,056	24,446	4,782	17,109	80
	Samfya	3,157	25,252	4,154	23,867	99
	TOTAL	17,341	138,715	27,993	122,540	96
Lusaka	Luangwa	418	3,341	449	3,084	94
	Lusaka Urban	30,860	246,880	35,178	156,488	69
Northern						
	Isoka	4,545	36,358	3,473	14,005	43
	Kaputa	1,206	9,648	0	2,157	
	Kasama	6,663	53,303	0	3,178	
	Mbala	5,136	41,089	4,213	20,038	52
	Mpika	4,641	37,130	7,558	18,051	61
	Mporokoso	2,691	21,526	3,587	12,078	65
	Mpulungu	1,381	11,047	3,247	10,617	112
	TOTAL	26,263	210,101	23,342	79,361	43
North-Western	Chavuma	600	4,800	734	4,800	102
	Kabompo	1,244	9,948	2,300	10,286	112
	Mwinilunga	3,528	28,224	2,703	19,436	70
	Solwezi	4,665	37,316	8,355	29,501	90
	Zambezi	1,253	10,020	2,910	9,467	110
Southern						
	Gwembe	1,112	8,894	813	7,615	84

Western	Kalabo	2,018	16,141	3,352	12,831	89
	Sesheke	954	7,632	1,816	9,583	133
	Shangombo	1,482	11,859	1,940	11,241	99
	TOTAL	5,330	42,642	8,707	43,754	109
	Total	107,195	857,535	133,634	675,209	84

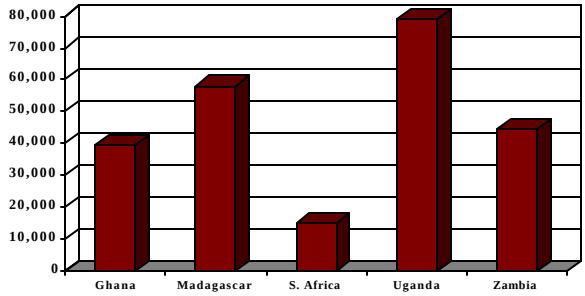
Vitamin A:
A Powerful Child Survival Intervention

- **USAID-supported field trials have established that vitamin A reduces overall child mortality within vulnerable populations by 19-34 percent. Examples:**
  - **GHANA—National Ministry of Health: Vitamin A supplements provided to preschool-age children every four months reduced child mortality by 19 percent.**
  - **NEPAL—Johns Hopkins University: Independent trials in two districts found that vitamin A supplementation reduced preschool-age child mortality by approximately 30 percent.**
  - **INDONESIA—Helen Keller International and Johns Hopkins University: The Aceh study was the first large vitamin A intervention trial, demonstrating that semi-annual supplementation of preschool-age children with vitamin A reduced mortality by 34 percent.**

Change in mortality among pre-schoolers in five countries due to vitamin A supplementation



Estimated number of preventable deaths in five African countries among children 6 mos.-4 yrs. with vitamin A interventions 1997-2002



How to Calculate the Number of Preventable Deaths in Zambia with Vitamin A Interventions

1. Calculate the estimated number of deaths among infants 0-1 yr. = estimated number of births x estimated infant mortality rate

2. Calculate the estimated number of deaths among children 1-4 yrs. = deaths among <5 (1) (as given in the UNICEF publication, State of World Children)

3. Calculate the estimated number of deaths among infants 6-11 mos. = 0.15 x (1)

4. Calculate the estimated number of deaths among children 6 mos.-4 yrs. = (2) + (3)

5. Calculate the estimated number of preventable deaths among children 6 mos.-4 yrs. with vitamin A interventions = (4) x estimated % reduced mortality among children 6 mos.-4 yrs. with vitamin A interventions (use Beaton et. al estimated 23% reduction)

Vitamin A Reduces Deaths from Measles and Diarrhea

Hospital studies in developing countries show that eliminating vitamin A deficiencies can reduce:

- **Measles deaths by 50 percent**
- **Diarrhea deaths by 40 percent**

Eliminating Vitamin A Deficiency

A simple solution to an overwhelming national problem

.

Benefits of achieving 80 percent coverage:

- **Child deaths and serious illness prevented**
- **Decreased demand on already hard-worked health care providers**
- **Decreased demand for scarce drugs and services**

Integrating Vitamin A Distribution into Child Survival Programs

- The MOH has proposed that vitamin A capsule distribution be used as a basis for regular twice-yearly child survival efforts.
- A special multi-sectoral task force has chosen "Child Survival Promotion Week" as the name for this new activity.

Child Survival Promotion Week

Twice-yearly vitamin A distribution:

- Provides a mechanism to integrate essential services for under-fives
- Works as a magnet to draw children who are too old for immunizations into the clinics
- Serves as a basis for organizing and providing priority services to this vulnerable population:
  - De-worming
  - Completing immunization
  - Sale of bednets
  - Nutritional counseling

Nicaragua: An example of successful integration of vitamin A distribution with child health services

Since 1984, twice-yearly integrated Health Rally Days have included VAC, ORS, de-worming, and routine (non-NIDS) immunization.

- VAC coverage—70 percent—is the highest in all of Latin America.
- ORS and de-worming coverage has risen.
- Routine (non-NIDs) immunization coverage has risen.

Vitamin A Distribution without NIDs?

- Can vitamin A distribution be successful without linking it to annual NIDs or sub-NIDs campaigns?
- What has been the experience in other countries?
- How has it been done?

Nepal:
A Model National Vitamin A Program

- Twice-yearly supplementation of all children age 6-60 months
- Began in 1993 and now in 52 of 75 districts
- Capsule coverage above 90 percent
- Program administered through government health infrastructure
  - Capsules distributed to district health offices, then on to health posts, and then through village health workers to female community health volunteers

Nepal National Vitamin A Program:
Elements of Success

- Campaign approach
- Community involvement and dedication of female community health volunteers
- Promotional activities
- Extensive field support by a local technical assistance group
- Mini-surveys to measure coverage and provide feedback

Workshop Orientation Session in Zambia

REPORT ON VITAMIN A ORIENTATION MEETING WITH DHMTS

1.0 INTRODUCTION

This was a two-day meeting for district health program managers and planners that took place on 29 and 30 July 1999 at Kafue Rimo Motel. Out of 34 invited districts only 3 did not attend. These were Chibombo, Kapiri Mposhi and Sinazongwe. Participants included Deputy Directors planning and Development Nutritionists, Public Health Nurses, Family Health Nurses and Environmental health Technicians representing each of their respective DHMTS. The main purpose of the meeting was to share with the 34 vitamin A focus districts (non-NIDs DHMTs) the essence, purpose and importance of the approaching 1999 Vitamin A supplementation campaign scheduled for the 20 and 21 of August. The meeting served to introduce the revitalized vitamin A supplementation which will strive to increase coverage from the current 23% to over 80% starting this year. At the meeting Vitamin A capsules, supplementation guidelines and promotional materials were distributed to the DHMTS.

The meeting intended to meet the following objectives:

i) To create awareness among health providers on the importance f vitamin A supplementation.
ii) To explore ways of increasing demand for vitamin A in the communities.
iii) To discuss implementation of vitamin A awareness campaign in August (1999) and February (2000) and;
iv) To demonstrate the administration of Vitamin A capsules to different target groups i.e. infants 6 to 11 months, and children 12 to 59 months.

1.1 These objectives, but the fourth, were met by going through the process presented below. Practical demonstration of vitamin A capsule administration could not take place mainly because of the time available for the meeting especially that the participants expressed knowledge of the skill form previous experience and that they could easily transfer that to any new staff in their districts. However, the issue was extensively discussed and participants expressed their major concern regarding availability of standard capsule cutting equipment. The meeting facilitators advised participants to use razor blades for cutting the 2000,000 IUs capsule, as a guide arrived at during the previous vitamin A task force meeting.

2.0 PROCESS OF THE MEETING

DAY ONE
PART I
The orientation meeting process progressed in four main phases.

2.1 Introductions and remarks from NFNC and MOST local (consultants) representative opened the orientation meeting. NFNC was represented by Fred Mubanga acting on behalf of

Priscilla Likwasi the Acting Executive Director. In his remarks he thanked the participants for coming, and reiterated the status of vitamin A supplementation as a component of the micronutrient program in the country. He further indicated that there was a general concern about the coverage levels of routine vitamin A supplementation which currently stand at 28%, and hence the critical need to make this year's August supplementation campaign a success in order to improve the coverage levels.

2.2 MOST local consultants introduced the MOSTproject to the participants, as the USAID micronutrient program, and its primary focus as the vitamin A problem in Zambia. That, for this year 1999 the priority or immediate task for the program was the August 20th 21st vitamin A supplementation campaign, which would be followed by similar campaigns in 2000 February and August. The consultant also provided a brief background to the orientation meeting that it emanated as a recommendation from the first Nation Vitamin A Main Task Force meeting on June 24th 1999. The role and contribution of the districts was emphasized as critical to the success of the vitamin A supplementation program in the country.

2.3 Presentations From Facilitator

Four facilitators managed the proceedings of the meeting, including guiding plenary discussions and distributing logistics. Basically, discussion of issues took place on the first day and distribution of logistics extended into the second day.

2.4 Group Discussions

The participants were divided into six groups, two groups for each of the three sets of subject questions to increase the scope of information on the concerns. Group constitution was based entirely on individual random selection rather than a deliberate formular accounting for any form of identity or district origin. The purpose was to ensure a richer information spectrum based on individual experience and perspective rather than a narrow information spectrum based on for instance, "group" district experience. Superior recognition was given to the fact that most of the implementation problems on the ground and experienced uniquely at individual level and their solutions may be perceived differently. Th motion of district experience was conceived as a collective of individual experiences rather than one solid whole. Accessing this wealth of diversity was of prime value to the purpose of the orientation meeting. Thus, for purposes of this particular session of the meeting, individual active participation was necessarily more critical than district participation per se'

2.5 Focal Discussion Issues

Interactive group work and plenary discussion focused on four key concerns considered as central to effectiveness of the vitamin A supplementation program

2.5.1 Low demand for vitamin A capsules by the community and health providers.

2.5.2 Problems/constraints encountered in vitamin A supplemention by health providers.

2.5.3 How to improve the vitamin A supplementation service

2.5.4 How to ensure quality service and increased coverage during the August 1999 vitamin A supplementation campaign

The above concerns were encapsulated in the three sets of questions designed for group discussion below.

GROUPS 1 AND 2-------QUESTIONS

a. Why is there low demand for Vitamin A capsules by the community
b. What can be done to increase demand for Vitamin A capsules?
c. What can be done for the August 1999 Vitamin A supplementation campaign?

GROUPS 3 AND 4-------QUESTIONS

a. Why is there low demand for Vitamin A capsules by health providers?
   Are there any perceptions about Vitamin A capsule by health providers?
b. What can be done to improve the service?
c. What can be done for the August 1999 Vitamin A supplementation campaign?

GROUPS 5 AND 6--------QUESTIONS

a. What are the major problems encountered in implementing Vitamin A supplementation?
b. What can be done to improve the Vitamin A supplementation service
c. What can be done for the August 1999 Vitamin A supplementation campaign?

2.6 Group Presentations And Plenary

Group presentations and plenary entailed open and sincere exchange of experiences, views and insight on the issues raised by the questions. Each group was accorded an equitable amount of plenary time on its topic depending on the issues it presented and the debate stimulated.

3.0 OUTPUTS

The outputs delineated immediately below include both common and unique group discussion results, including those that emerged from the plenary session Here they have been refined, as much as possible, for presentation purposes but without any attempt to shift their essence and originality.

3.1 Reasons for Low Demand for Vitamin A Capsules by Community

3.1.1 Ignorance by mothers and the community on the importance of vitamin A and consequences of vitamin A deficiency.

3.1.2 Misconceptions among caretakers some of who believe the Vitamin A capsule may cause barreness.

3.1.3 Some religious organizations forbid consumption of allopathic medicinal products especially for prophylactic purposes.

3.1.4 Poor, uncaring reception at health service posts often discourage caretakers from going back to demand the service for the second time.

3.1.5 Distance between caretakers and health posts is also a deterrent factor in demand for vitamin A supplementation services

3.1.6 Lack of information in communities about availability of vitamin A supplementation services at their health posts.

3.1.7 Shortage of health worker staff at the community health posts, a factor which contributes to work overload at the clinical level and hence low priority given to preventive activities which include vitamin A supplementation. Staff restrict their limited capacity to clinical services

3.2 To Increase Demand for Vitamin A Capsules by Community

3.2.1 IEC for caretakers in the communities on the benefits of vitamin A supplementation, both for mothers and children, and WHEN/WHERE to receive the supplementation.

3.2.2 Orientation courses for health providers on quality service provision that would encourage mothers and other caretakers to continue demanding vitamin A supplementation. This should not only involve health centre staff but also community health workers. Traditional Birth Attendants and other community based health providers.

3.2.3 Ensure availability of vitamin A capsules in all strategic areas, including health centres and community health posts. Consistency in stock availability aids in the creation and sustenance of the caretakers confidence in the service system.

3.2.4 CBOH should 'honor' approved district action plans and maintain consistent and reasonable district funding regimes

3.2.5 Integrate vitamin A in MCH supportive visit schedules as a way of keeping the vitamin A demand/supply line 'live'

3.3 What To Do For The August 1999 Vitamin A supplementation Campaign.

3.3.1 Brief DHMT on the August vitamin A supplementation campaign

3.3.2 Form a district Vit. A Supplementation campaign Task Force and committees responsible for various tasks such as social mobilization and logistics.

3.3.3 Orientation meeting for health centre staff, who should in turn sensitize community based health providers.

3.3.4 Social mobilization by community based health workers

3.3.4 Resource mobilization: finances, Vitamin A capsules and promotional materials.

3.3.5 Evaluation and monitoring

3.4 Reasons for Low Demand for Vitamin A capsules by Health Workers

3.4.1 Health providers do not understand the importance of vitamin A

3.4.2 There has been no concerted emphasis in the national health services system on importance of vitamin A. The system by which vitamin A was introduced into the NIDs was not well planned because often nobody gets concerned about Vitamin A once the NIDs have passed

3.4.3 Vitamin A has not been a felt priority in district action plans, and it never appears there.

3.4.4 Work overload due to inadequate staffing levels in primary level health institutions means that the few serving staff accord low priority to vitamin A, as their efforts get concentrated on clinical services

3.4.5 Vitamin A capsule is taken as a drug provided on prescription by the clinician or doctor. If not prescribed no health worker would provide it as a prophylaxis on routine basis.

3.4.6 Lack of knowledge among health workers on how to routinely procure the vitamin A capsule especially for routine supplementation particulary because they seem to receive their stocks in a year only during the NIDs.

3.4.7 Prevalent misconception among health workers that they might cause overdose in the recipient because of existence of vitamin A fortified foods on the market, especially the locally produced vitamin A fortified sugar.

3.4.8 There is also fear of possible overdose because there is not standard provision for 'cutting' the 200,000 IUS vitamin A capsule. This makes vitamin A difficult to administer.

3.5 To Increase Demand for Vitamin A Capsules by Health Workers

3.5.1 Sensitization of health workers and provision of information on vitamin A to them. This includes vitamin A supplementation policy

3.5.2 Incorporation of vitamin A into existing programs, including integrating it in the essential drug kit.

3.5.3 Intensification of vitamin A awareness campaign in the community to generate demand.

3.5.4 Inclusion of vitamin A supplementation activities in the district annual plans.

3.5.5 Ensure its inclusion in the HMIS reporting system

3.5.6 Include vitamin A in the supervision checklists at the primary level

3.6 What To Do For The August 1999 Vitamin A Supplementation Campaign.

3.6.1 Brief the DHMT on the problem. In turn the DHMT should orient the health centre/post staff and provide them with guidelines

3.6.2 Involvement of local community level structures in social mobilization community health workers, Traditional Birth Attendants, neighbourhood health committees, churches, community leaders, and so forth.

3.6.3 Logistics must be distributed in time, preferably before the cascade of orientation meetings at the district level.

3.7 Major Problems Encountered In Implementing Vitamin A Supplementation

3.7.1 Vitamin A supplementation is not taken as priority, nor seen as a necessity, by health providers. For instance, the link between vitamin A deficiency health problems and vitamin A is not commonly appreciated

3.7.2 Vitamin A capsule is inaccessible to 'frontline' health staff, since it is kept in pharmacies and only issued on prescription by clinicians

3.7.3 Because vitamin A is only dispensed as a drug on prescription, its use is confined to clinicians.

3.7.4 Health workers do no consider vitamin A supplementation a priority

3.7.5 Possible inaccuracies in administering it, especially when using 200,000 IUs to children of 6-12 months age and the capsule has to be cut

3.7.6 Misconceptions at community level compound the problem of low demand for vitamin A by caretakers.

3.7.7 Vitamin A supplementation, or even activities in general, do not receive strategic planning.

3.7.8 Poor reporting system does not allow efficient flow of accurate information on vitamin A activities and their impact

3.7.9 Poor resource levels at the district level.

3.8 To Improve The Vitamin A Supplementation Service

3.8.1 Sensitization of health providers, including training and provision of administration policies.

3.8.2 Sensitization of DHMTs to ensure inclusion of vitamin A supplementation in district annual plans.

3.8.3 IEC for community awareness.

3.8.4 Introduce the 'supermarket model' for the vitamin A supplementation service where caretakers can walk into a health centre or community health post and demand for it anytime as log as it is appropriate

3.8.5 Re-orient community based health providers like community health workers, Traditional Birth Attendants.

3.8.6 Involve community instutions and leaders: churches, neighbourhood health committees, village headmen.

3.8.7 Develop effective reporting system and ensure inclusion in HMIS

3.8.8 Adequately resourcing the districts for implementation of vitamin A supplementation program plans.

3.9 What To Do For The August 1999 Vitamin A Supplementation Campaign

3.9.1 Brief the DHMT on the problems relating to vitamin A supplementation and essence of the campaign. The DHMT should in turn sensitize the health centres and community health posts.

3.9.2 Form a district intersectoral committee for the campaign

3.9.3 Massive publicity and education about vitamin A and vitamin A supplementation. Social mobilization.

3.9.4 Logistic to be available in time.

3.9.5 Adequate financial resources for the campaign

3.9.6 Monitoring and evaluation.

PART II

Part of the first day was spent on Refund of travel expenses, and out of pocket allowance, and distribution of logistics also started on the later part of Day One. The logistics distributed included the elements of the 'district kit'

Vitamin A Capsules - 200,000 IUs
Promotional materials
Supplementation guidelines
Why Supplement? booklet
Reporting Forms

DAY TWO

Distribution of logistics to the participants continued.

4.0 CONCLUSION

The information delineated above out of the discussion with participants from the districts suggests a few key pointers to the overall character of health services in relation to the vitamin A supplementation program in Zambia, that:

4.1 There is apparent general lack of awareness among caretakers in community about vitamin A, its benefits and where to get it from.

4.2 There is apparent general lack of appreciation, among health providers of the benefits of vitamin A, an how to provide it to the communities or in fact the need to do so.

4.3 There is general lack of resources available for effective implementation of the vitamin A supplementation program in the districts, and these include both human and financial resources.

4.4 Vitamin A generally appears to receive low priority at all key levels within the national health services system. This is evident in the low prioritization of vitamin A at the district or primary level that has for long not received critical address by the executive sectoral policy makers at the central level. Its current absence from the HMIS may be another critical indicator of the low prioritization factor.

5.0 RECOMMENDATIONS

The observations made in the conclusion above suggest the need for a long term step to facilitate a profitable vitamin A supplementation program in Zambia

5.1 There is need for a comprehensive national vitamin A supplementation strategy which may be a component of the child survival program in general or, and especially the overall national vitamin A program. Within this national vitamin A supplementation strategy, the various inadequacies (indicated above) that currently inhibit the efficient and effective implementation of vitamin A supplementation may be addressed. The following key areas of concern as highlighted by the meeting:

5.1.1 Advocacy to the policy making echelons of the health sector

5.1.2 IEC for consumers in the communities across the country

5.1.3 Training of health providers at key identified levels within the health services system.

5.1.4 A clearly designed vitamin A supplementation delivery system, from procurement, distribution and administration of the vitamin A capsule. Within this delivery system must be built a reliable monitoring system with clear indicators on the HMIS.

5.2 Among the major challenges to the designers of the strategy would be how to ensure the supplementation strategy's integration with established health service programs, without necessarily verticalizing it.

Creative Briefs*

The creative brief is both a process and a product. The process is to think, decide, and write out the elements needed by the people who will create (write) and perhaps go on to produce the program materials. The brief should translate all the steps completed thus far into feasible communication objectives and show how they should be distributed among various channels of communication.

Writing the creative brief is a crucial step. It is an instrument that forces you to restate your target audience, communication objectives, obstacles to be expected, key benefit, support statements, tone of the messages, communication channel to be used, and other necessary creative considerations such as different language versions or gender considerations.

The brief assures that all partners in the intervention are in agreement on the key elements and the communication strategy and that the materials created will reflect the analysis that you have done. Whether your team itself is going to undertake the task of creating the materials or is going to have this task done by an outside creative team (copywriter/art director) or advertising agency, drawing up the creative brief assures clear definition of the communication objectives, paints a clear picture of audiences, and integrates relevant research findings.

The creative brief is prepared for briefing (1) the team members or the selected firm for the creative development of the materials and (2) your team members (or the Ministry authorities) for giving them a precise idea of what the communication is meant to accomplish.

Importance of a Creative Brief. The creative brief is important because it

- Is a crucial link between research and communication strategy.
- Helps you translate all background information into actual materials.
- Ensures that your interventions will reflect and address the concerns and needs of your audiences.
- Is like a contract between the client/manager of the intervention and the creative people.

Elements of a Creative Brief. A creative brief includes the following elements:

- *Target Audience.* Who do you want to reach with this communication?
- *Communication Objective(s).* What will this communication make the audience feel, think, believe, or do?
- *Obstacles.* What beliefs, cultural practices, pressures, and misinformation stand between your audience and the communication objectives?
- *Key Promise/Benefit.* What is in it for the audience? What is the benefit of doing, thinking, or feeling what you want them to do? Be single minded!
- *Support Statement/Reasons Why.* Why does the key promise outweigh the obstacles?
- *Tone.* What feeling should this communication have?
- *Media.* What channel(s) will you employ to best reach your audience?
- *Creative Considerations.* What additional points need to be considered while designing this communication?

Following are forms that can be used in developing your own creative briefs, as well as examples from Ghana and Zambia. These were developed primarily to be used by spokespersons in radio interviews, community discussions and other face-to-face activities. This allows these spokespersons to act as advocates for the programs, and assures that messages are consistent, focused on the main barriers to adoption of the desired behaviors, and technically correct.

* Adapted from A Tool Box for Building Health Communication Capacity, AED, April 1995.

The Creative Brief

1. Background

What is the background of this intervention? Why are you doing it?

2. Target Audiences

Who do you want to reach with your communication? Be specific.

3. Objectives

What do you want your target audience to do after they hear, watch, or experience this communication?

4. Obstacles

What beliefs, cultural practices, pressures, and misinformation stand between your audience and the desired objectives?

5. Key Benefit

Select one single benefit that the audience will experience upon reading the objective(s) you have set.

6. Support Statements/Reasons Why

These are the reasons why the key benefit outweighs the obstacles and the reasons that what you are promoting is beneficial. These reasons often become messages.

7. Tone

What feeling should your communication have? Should it be authoritative, light, or emotional? Pick a tone.

8. Media

What channel(s) or form will the communication take? Television? Radio? Newspaper? Poster? Point-of-purchase? Flyer? All of the above?

9. Creative Considerations

Is there anything else the creative people should know? Will it be in more than one language? Should they make sure that all nationalities are represented?

Creative Briefs/Talking Points
Examples from Ghana and Zambia

Ghana

In Ghana, as elsewhere, promotion of vitamin A during the NIDS will occur primarily during radio, TV and personal talks and interviews that will often be associated with the NIDS preparation. The Nutrition Unit of the MOH and MOST developed several Creative Briefs or Talking Points that outline the key behaviors to be promoted, vitamin A messages, barriers to participation that should be addressed, audiences for various messages, and credible statements that can be used to bolster and support the messages. Included were "short" messages for those occasions where the NIDS agenda left little time for special vitamin A messages. It is expected that these briefs will help all sources of information stay on message and on strategy, giving clear, consistent and priority messages. Ghanaian examples follow.

Talking Points Directed to Health Workers

Target Audience: Health workers or others who will be distributing capsules or who can act as advocates for the distibution.

Objective: Help providers understand impact of VitA on child health; advantages to health services and communities; value of the distribution in improving HW image, and in lessening demands on Health Services.

Desired behaviors: HW will assure adequate supplies of VAC for two distributions a year in addition to those needed for treatment. They will encourage mothers to bring children at the appointed times. They will tell mothers their children are receiving vitamin A, give the agreed upon positive messages, and thank the mother for coming. They should check the child's age to assure adequate dosing, and record and report the doses in the agreed upon format.

Obstacles: HWs often do not give priority to nutrition or preventative services, are not aware of the important health benefits in preventing child deaths. HW are busy and lack resources and see no pay off to them in investing extra time or energy into the distribution. May lack confidence in ability to administer capsules correctly.

Key Messages:
Need for provider's participation: In Ghana recent studies have shown that 65% of children under five in the North, and over 37% of children in the South are severely vitamin A deficient. WHO considers this level of deficiency a serious public health problem. Studies in Ghana and other countries in Africa show that providing vitamin A to deficient children will save approximately 20-30 % of them from death. Vitamin A saves lives. It helps children resist dangerous illnesses such as measles and diarrhea.

Call for Action: Health workers and other providers will be providing vitamin A capsules free at the NIDs for all children 6 months to five years. Vitamin A is needed twice (three times) a year for these children, so four to six months after the NIDS health workers should encourage parents to bring children into health centers and other distribution sites for another dose. Parents should be reminded to watch for notices of distribution.

Key benefits to the health care system: Providing vitamin A to deficient children will make health care more effective and decrease demands on scarce clinic time and supplies. Communities will appreciate the HW for providing VAC. The Vitamin A contacts can be used to provide other services, as immunization and growth monitoring, especially to older children (2-5) who do not usually come to the clinics.

Talking Points Directed to Mothers and Those Who Influence Them

Target Audience: 1. Women and caretakers of children under five, especially those with children between two and five.
2. Fathers of children under five
3. Village leaders

Objective: To encourage mothers and other family members to value vitamin A for their children and to be sure that their children receive vitamin A at least twice a year. To encourage fathers and village leaders to support caretakers who make sure their children are covered, and to recognize and show appreciation to mothers and other caretakers when they do so.
To clarify who is eligible, when supplements are given, where they are given, and why.

Desired behavior: All children six months to five years should receive vitamin A at least twice a year. Parents should take these children to a nearby health facility or outpost for NIDS ana again after six months for another free dose. Listen for announcements for the next free distribution.

Obstacles to be aware of: Mothers are busy and may not think vitamin A capsules are important enough to invest their time; may not know where or when, may not like the health services, may fear capsules.

Key messages: Many children in Ghana lack enough vitamin A (over half the children under five in the North and a third of the children in the South do not have enough vitamin A). Vitamin A helps children to fight serious illnesses like measles and diarrhea. According to studies done in Ghana and other nations in Africa and the world, if all children get enough vitamin A child deaths can decrease 20-30 %. Vitamin A will help your children grow strong and healthy.

Short Messages (when there is not enough time for longer messages): Many children in Ghana lack enough vitamin A. Vitamin A helps children fight serious illnesses like measles and diarrhea. Studies in many Africa countries show good Vitamin A coverage can save one child in four from death and help children grow well and be strong. Vitamin A will be given free at the NIDs February 19th. Bring all children age six months to five years on February 19th for free vitamin A.

All children 6 months to five years should receive vitamin A at least twice a year. Special distributions will be announced through your health centers, communities or schools. Listen for the announcements and be sure your child gets vitamin A at each opportunity.

Fathers and leaders in the village should encourage mothers to be sure their children receive vitamin A during the NIDs and twice a year after that. Mothers who see to it that their children receive vitamin A twice a year should be praised by the fathers and community leaders for their action.

Zambia

In Zambia, the National Food and Nutrition Commission and the Zambia Integrated Health Project, a USAID bilateral, worked with MOST to define the key points, audiences and objectives for official announcements, radio and interpersonal talks, as well as short print materials. These were helpful in assuring that all statements reflected the strategy and key messages agreed to by the group. Examples follow.

Creative Brief for Families

Background: VAC has been most successful when linked to NIDs. Routine or non-NIDs distribution has had relatively poor coverage. This year the VitA Focus Areas (VAFA) regions will have no NIDs to build coverage. It will be key to find ways to motivate mothers and families to bring their children to the health centers in August even without the NIDs support

Target Audiences: The most difficult to reach are the children from two to six, who have completed their immunizations. Therefore, the primary target group is mothers of children two to six years, next the families of these children, thirdly, the families of children six months to two years.

Objectives: Families will bring their children of six months to six years to the health centers/posts on August 20-21 to receive VAC.

Obstacles/barriers.
Distance/time/effort
Kids not sick
No information on benefits, why should they bother?
Possible fear of capsules/virus/unsafe/sterilizing/related to FP
Mixed messages/confusion

Key promise/benefit:

Mothers/families will be happy and confident once they have taken their children for VAC.
Mothers/families will know they are good parents who take care of their children.

Support Statements: Because

VAC protects my child from serious disease and saves lives.
I have protected my child from blindness
VAC is free and has no side effects or dangers

Tone: Personal, emotional, parent –to- parent, reassuring, warm.

Source of Information/Voice of authority:

(radio/cassettes) Doctor or nutritionist who is also a parent/ possibly male/father for males and female/mother for females. Should reflect health service support.
(interpersonal communications) Influential community leaders

Media: Radio, cassettes for mobile vans and regional radio stations, TV (? May be too costly and difficult t do in time remaining), public meetings, newspapers. Posters can be used to identify point of supplementation.

Special considerations: Cassettes/audio tapes and regional radio should use four prime languages if funds/time permit.

Creative Brief For Health Workers

Background: In August, many HW will be distributing VAC without NIDs for the first time. They have not yet been informed of the upcoming distribution and have not yet come to expect it as a regular routine. They will need to be motivated and supported in achieving good coverage and reporting.

Target Audiences:

HW who will distribute VAC and their District Managers
NGOs
Neighborhood Health Committees

Objectives: HW will

Provide VAC in correct dosages to correct ages
Organize Community Mobilization (maybe district level staff does this?)
Tell mothers their child is receiving vitamin A
Praise/welcome mother/family for bringing their child
Remind them when to return (February)
Keep records/tallies
Send coverage reports in to Central Level

Obstacles/barriers:

Have little information on what is planned
Don't see value of VAC/VitA, attach no importance to VAC/VitA
Very busy
Lack experience with VAFA Campaigns
Lack of VAC/promotional materials/ (scissors)
Lack of knowledge about VAC administration, dosages and ages, and how to cut capsules if needed.
No habit/system of reporting VAC
Lack of staff

Key promise/benefit:

You will feel pride in doing a good job.
You will help to decrease illness & demand on health services and medications in the future.

Support statements:

Because VAC can reduce child illness and death (diarrhea, ARI, Measles, Malnutrition, eye infections and blindness)
VAC can help to reduce demand for scare services, time, drugs (this needs work. Maybe talk to some HWs to find out what they think?)
Children and their families will come for VAC who do not usually come to HC, and they can be offered other services (immunizations, deworming, sale of bednets, etc.)

Tone: Knowledgeable, professional, scientific, sympathetic (we know you have little time, many tasks, etc.)

Source of information, voice of authority:

Minister
DHMs
Provincial Ministers

Media:

Ministry letter to be read over radio, at meetings
Radio
Presentations at DM meetings/ provincial level meetings

Special considerations: ?

Example of a Household Survey

CHILD SURVIVAL WEEK: HOUSEHOLD QUESTIONNAIRE
Enumerator Guideline

For use following the February, 2000 Child Survival Promotion Week DRAFT: Feb, 2000

Household Identification This provides basic information on the households selected

Province: _____ Date [___]/[___]/[___]
(Enter dd/mm/yyyy)

District; _____

CSA Number:..... [_____]
(Census supervisory areas-will be provided)
SEA Number: ..... [_____]
(Standard enumeration area–will be provided)

Type of community; [__]
1. Urban
2. Rural

(Based on CSO classification of urban vs. rural communities)

Name of Household Head _____

Who usually takes the child to the under 5 clinic?
1. Mother [__]
2. Father
3. Sibling
4. Relative or maid
5. Neighbor

(This question identifies the most likely caretaker, the best person to answer the questions on whether the child got a capsule. Since someone other than the mother may have taken the child for the vitamin A distribution, it is important to try to find out who that person was. In some instances the child may have gone with a neighbor, a sibling or another person. Usually someone in the household will remember the distribution event (campaign), and this is the best person to ask.)

[address questions to the identified person if possible]

Respondent [__]
1. Mother
2. Father
3. Sibling
4. Relative or maid
5. Neighbor

Respondent Education [__]

1. no formal education
2. Primary school
3. Secondary school
4. College / University

Respondent's Marital Status [__]

1. Single
2. Married
3. Divorced
4. Widowed
5. Separated

Number of children under 6 years old [__]
(determine the total number of children less than 72 months old living in the household)

(Select one child at random)

Instructions:

Write the first name of each name down on a small piece of paper–each on a separate small piece. Fold these and conceal in your hand. Ask the respondent or colleague to close their eyes and select one. All the following questions should be asked about this randomly selected child.

Age of selected child (in months) [__]

Vitamin A Deficiency Control Programme.

Do you remember the Child Survival Promotion Week?
1. Yes 2. No [__]

If Yes: Please describe what happened:
___Red or blue capsule mentioned
___Cutting of the capsule mentioned
___Correct distribution site (health facility or outpost) mentioned
___immunization received
___other child survival intervention received: Specify_____
___health education received. What was the topic? _____
Instructions: For the above question, do not prompt, but check those things that the respondent mentions spontaneously, on their own. Only ask this question to those who said they remember the Child Survival Promotion Week.

Did your child receive a vitamin A capsule recently?
1.Yes 2. No [__]
If yes:
Please describe what happened:

___Red or blue capsule mentioned
___Cutting of the capsule mentioned
___Correct distribution site (health facility or outpost) mentioned
___immunization received
___other child survival intervention received: Specify_____

Instructions: For the above question, ask whether a vitamin A capsule was received, and do not prompt for the answer, but just check those items mentioned spontaneously.

If no:

Did [name of child] ever receive a vitamin A capsule (supplement) like this one?

[Show capsules and check immunization card]

(The enumerator should have several of the red 200,000 IU capsules and of the blue 100,000 capsules, and also perhaps some of the yellow round capsules. These can be shown, asking the respondent to note which one was given.)

1. yes [__]
2. No

(There may be confusion with polio, which is also given by mouth. It is important to try to distinguish, by asking the following questions carefully.)

How many weeks ago did [name of child] take the last dose of vitamin A?

1. Less than 4 weeks (< one month) [__]
2. 4-7 weeks ago
3. 2 months ago
4. 3 months ago
5. More than 3 months ago

(This question can be used to confirm that the event described fits with the actual timing of the vitamin A distribution event)

Where did [name of child] get this last dose? [__]

1. On routine visit to health center
2. Visit to health center for illness
3. During NIDS (which was in August, 1999)
4. During Child Survival week (vitamin A campaign)
5. Other _____(specify)

Knowledge on Vitamin A deficiency

Before today, had you heard about vitamin A? [__]

1. yes
2. No

If yes, what did you hear about it?
(Check all that respondent mentions–do not prompt)

1. Good for health [__]
2. Good for eyes [__]
3. Protects children [__]
4. Sick children get well faster [__]
5. Other_____
6. Don't know [__]
7. Any negative association [__]

(Such as causes sterility, weakness, vomiting, makes children sick, or any other negative association)

(This question is designed to determine whether mothers understand the importance of vitamin A, or whether there are negative rumors about vitamin A. Do not prompt for this question, but just mark all that apply)

Where or how did you hear about vitamin A? (DO NOT PROMPT)

1. Mass media (radio or TV) [__]
2. Print media [__]
(poster, leaflet, calendar)
3. Health workers [__]
4. Neighbor or other family friend [__]
4. Community group member or volunteer [__]
5. Other_____
6. Don't know [__]

(For this question, first check all the responses that the respondent mentions on their own, without prompting.)

Were you happy with the information you got?

1. Yes [__]
2. No

(This question hopes to determine if the contact with a person was positive, or if the information from a poster was interesting and informative.)

How can your child get enough vitamin A?

1. From vitamin A capsule [__]
2. From fortified sugar [__]
3. From food (Mark if any of the following are mentioned: green leafy vegetables, orange fruits or vegetables or food of animal origin) [__]

(This question is designed to determine knowledge about sources of vitamin A. Most will mention capsules, since they have been discussed already. Some may mention fortified sugar. Many will mention food, but only mark #3 if the specific foods are mentioned.)

(Ask next question for those children who DID receive a vitamin A capsule)

Have you observed any benefit from the vitamin A capsule?

1. Yes [__]
2. No

Describe:

___recovers more quickly from illness
___is sick less often
___sees better at night
___Other: specify:_____

Instructions: Ask the respondent to describe the benefit, and check those items mentioned by the respondent spontaneously–do NOT prompt for an answer.

Do you intend to take this child again to get a vitamin A capsule?

1. Yes [__]
2. No

If yes, when? ___February ___August Other:_____

(This question is designed to determine whether caretakers know that vitamin A capsules are needed every 6 months. Ideally, caretakers partake in the campaign, and therefore, the next dose is in August following a February campaign.)

Why will you take your child? Please describe:

_____

Vitamin A sugar fortification.

Do you have sugar in the house today?

1. Yes [__]
2. No

If yes, how many days ago did you buy it? [__]

(This question is designed to determine how many households have sugar currently, and how long they have had it, since some vitamin A is lost with long storage periods.)

Did (name of child) have sugar or food or drink with sugar in it today?

1. Yes [__]
2. No

About how many times in the past week did (name of child) have sugar or food or drink with sugar in it?

1. Once [__]
2. Twice
3. Three times
4. More than three times

(This question is trying to determine how much sugar is given to children–is fortified sugar likely to help reduce deficiency. Perhaps only adults in the house consume sugar.)

About how much sugar does this household use in a given week?

1. Less than 500gms [__]
2. 501gms to 1kg
3. more than 1 kg

What type of sugar do you usually buy?

1. Local [__]
2. Imported

(Since all sugar sold in Zambia is supposed to be fortified, by law, this question is to determine whether households prefer imported (probably non-fortified) sugar.)

Do you normally buy sugar in its original paper package, or in smaller repacked unlabeled plastic bags?

1. Original paper package [__]
2. Repacked unlabeled plastic bag

(It is common in Zambia for small shopkeepers to repackage sugar in smaller plastic bags. Most of this will be fortified, since it is repacked from Zambian Sugar that is fortified. However, it may be that vitamin A is lost more easily from the repackaged sugar, and this question is to determine how many households use repacked salt.)

[If household has sugar in the house today, collect a small sample for analysis. Check below if sample was collected.]
(More data are needed on whether vitamin A is lost during the period from production to consumption. These samples will be analyzed for vitamin A content.)

Sample was collected from this household. [__]

1. Yes
2. No

Please note whether the sample is labeled?

[__] labeled as fortified [__] labeled but not fortified
[__] no label [__] home package or no packaging